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ABSTRACT

This report details family planning service delivery at the state level and presents state administrators' views about service delivery and policy options for the 1990s. Data for the report were obtained from telephone surveys of 109 State Administrators from the Title X, Maternal and Child Health Block Grant, Social Services Block Grant, and State and Medicaid programs. Following the introduction, the report is comprised of nine sections: (1) a description of study methodology and the respondents; (2) an overview of family planning service delivery at the state level, including funding streams, how states allocate family planning revenues, reporting requirements, and state regulations on family planning service provision; (3) a review of family planning services paid for by Title X, Maternal and Child Health, Title XX, and State monies in 1991, highlighting special family planning initiatives and special populations targeted by Title X Grantees; (4) an overview of reversible contraceptive care covered by managed care programs under Medicaid; (5) a review of changes in funding and demand for Title X services during the 1980s, including how Title X Administrators responded to shifts in funding and client demand; (6) a discussion of the difficulties Title X Administrators encountered in delivering family planning services since 1990; (7) a presentation of perspectives of state program administrators regarding ways to improve services to low-income women; (8) a description of Title X administrators' reactions to five policy scenarios for future family planning service delivery; and (9) a review of implications of findings for family planning policy and health care reform. Contains 11 references. (KB)

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STATE FAMILY PLANNING SERVICE DELIVERY: ADMINISTRATORS' PERSPECTIVES ON SERVICE DELIVERY AND OPTIONS FOR FUTURE FAMILY PLANNING SERVICES

by

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PREFACE

This report is the fourth in a series prepared for the Henry J. Kaiser Family Foundation which examines the status of publicly funded family planning services in the United States. It explores family planning service delivery at the state level and presents state Administrators' views about service delivery and policy options for the 1990s. Taken together, these reports examine how well Federal programs have been able to provide reversible contraceptive services to low-income women and other populations in need. These reports are intended to inform public discussion about family planning services in the coming decade, and the role of the public sector in supporting reversible contraceptive care.

During the 1960s and 1970s, family planning enjoyed substantial growth due to Federal initiatives and support. The 1980s, however, witnessed a shift both in funding and support for family planning. For example, during the past decade funding for Title X of the Public Health Service Act was cut, while the Maternal and Child Health (Title V) and the Social Services (Title XX) programs were folded into state block grants. Funding for family planning through these latter programs was not only reduced, but requirements to provide family planning services with these monies were removed. Furthermore, budget cuts were coupled with regulations about service provision, although regulations concerning abortion counseling, the "gag rule", were suspended by the Clinton Administration. In addition, Medicaid has replaced Title X as the primary source of funding for family planning (Ku 1993), and Federal support for research and data collection of program statistics has diminished. As a result, there is a paucity of information about services delivered, populations served or changes in need or service provision.

Funding and legislative changes were not the only challenges confronting family planning providers during the past decade. The 1980s saw an increase in the number of births to young women, a rise in rates of poverty, sexually transmitted diseases (STDs) and infection due to the Human Immunodeficiency Virus (HIV), all presenting new challenges to family planning providers.

Against this backdrop, the Henry J. Kaiser Family Foundation commissioned the Urban Institute

and Child Trends, Inc. to examine the status of publicly supported family planning services in the United States as a starting point for discussions regarding options for family planning policy for the 1990s. Other components of the study include:

(1) an account of the legislative and policy history of family planning services in the United States (Burt 1993);

2) an evaluation of family planning service utilization by women in need of family planning using the National Survey of Family Growth (Levine and Tsoflias 1993);

(3) a review of public financing of family planning services during the 1980s (Ku 1993);

(4) a survey of family planning clinic managers and line workers regarding service delivery and family planning clients (Burt, Aron, and Schack 1994), and;

(5) a survey of family planning clients to understanding preferences for and experiences with family planning service providers (Sonenstein, Schulte, and Levine 1994).

Each of these components is available in a separate report. A final project report integrates these findings, examines policy implications and outlines recommendations for future family planning service delivery.

ADMINISTRATORS' PERSPECTIVES ON SERVICE DELIVERY AND OPTIONS FOR FUTURE FAMILY PLANNING SERVICES

EXECUTIVE SUMMARY

The Survey of State Family Planning Administrators is one part of a collaborative effort carried out by researchers at the Urban Institute and Child Trends, Inc. Commissioned by the Henry J. Kaiser Family Foundation, the full project reviews the evolution of publicly supported family planning through the 1980s, and examines possible directions for the 1990s.

The Survey of State Family Planning Administrators referred to hereafter as the "State Survey", augments other project reports by examining family planning service delivery at the state level. The purpose of the State Survey is to take stock of state-level family planning service delivery, and to garner Administrators' insights about future policy for family planning services. Particular attention is given to services funded by Title X of the Public Health Services Act. One-hundred nine (109) State Administrators from the Title X, Maternal and Child Health Block Grant, Social Services Block Grant, State and Medicaid programs were interviewed by telephone during the winter and through the summer of 1993.

All administrators were asked to describe several aspects of service delivery, including services covered by public funds, and recommendations for improving family planning services for low income women. Title X administrators were asked to provide comments on shifts in Title X funding and demand for services, and administrative responses to changes in revenues and client needs. Title X administrators also provided reactions to future policy options for family planning. The main study findings are presented below.

MAIN FINDINGS

Description of Family Planning Service Delivery at the State Level

State family planning service delivery via public funds is conducted primarily through a system of Title X and non-Title X Grantee Agencies that consist of state and regional family planning networks. State Title X Grantees are more likely than non-State or regional Title X Administrators to receive public funds other than Title X for family planning service delivery. Several states with non-state Title X Grantees are heavily dependent upon Title X monies for the delivery of reversible contraceptive care.

- Slightly more than one half of all states have a State Title X Grantee Agency that distributes Title X monies for family planning; 25 percent of all states have a non-state or regional Title X Grantee, and 20 percent have a state and non-state Title X Grantee(s). On average 2 Title X Grantees (state or non-state) per state carried the responsibility for administering Title X family planning services.

- Fifty-seven percent of State Title X Administrators also received additional family planning monies from MCH and general state revenues. Forty-six percent of non-state Title X Grantees receive no additional public monies at all in 1991; in five of these states, the non-state Title X Grantee is the only source for Title X family planning services for the entire state.

States vary in how they allocate Title X monies to local family planning providers and how they monitor family planning activities at the local level. For example, allocation of monies is determined primarily by a mixture of historic and subjective data. In fact, some states report that no specific allocation formula at all is used to determine how Title X funds will be dispersed. Administrators usually require clinics to report on clinic expenditures, clients served, and services provided.

- Fifty-six percent of Title X Grantees use the number of clients served and the local provider's prior funding level to determine the amount of Title X monies it should receive. Forty-three percent of Title X Administrators consider the number of women in need, and thirty-eight percent consider the poverty of the provider's local area and one-fourth consider the availability of other public funds; ten percent of Title X Administrators employ no explicit allocation formula.

- More than 90 percent of Title X Administrators request information on program expenditures, patient characteristics and family planning services rendered to help monitor service activity at the local level; eighty-six percent require a line item budget.

Reversible Contraceptive and General Reproductive Health Care

Public family planning revenues covered a broad range of family planning and reproductive health services; Title X monies were used more often than other sources for HIV related services in 1991, and few public dollars were used to provide NORPLANT.

- More than 80 percent of Administrators reported using their MCH, Title XX and State revenues for contraceptive and pregnancy related services, and between 70 percent and 75 percent of all Administrators used these monies to provide services to male clients.

- Title X was the funding source most commonly used to provide HIV related services. More than half of Title X Grantees reported providing HIV screening and counseling with their Title X monies; about one-third of non-Title X Administrators used public monies to conduct HIV related services.

- NORPLANT was the reversible contraceptive least likely to be provided via public funds. Less than one-third of all Administrators reported using public monies, via any source, to provide NORPLANT.

Public family planning revenues also covered a broad range of special family planning initiatives; Title X revenues were used more often to cover a broad array of special family planning services, and services for special populations.

- Sixty percent of Title X Administrators report using Title X monies for family planning initiatives other than reversible contraceptive care; one-third of administrators report using MCH monies for special family planning initiatives.

- Special initiatives covered by Title X included professional training programs (10 percent), HIV safe sex programs (10 percent), referral and follow-up services for abnormal Pap smears (8 percent) and targeting high risk populations (7 percent); MCH monies were used primarily to provide special care for high risk populations (30 percent).

Title X Funding Constraints and Problems with Service Delivery

Administrators reported that Title X funding was insufficient to meet the demand for services during the 1980s

- Eighty-eight percent of Title X administrators noted a decline in Title X funding between 1980 and 1989. Less than 3 percent reported an increase in Title X funding, and 7 percent saw their Title X dollars remain constant over the decade.

- Ninety-eight percent of Title X Administrators reported that funding generally fell short of service needs; in fact, 85 percent of Title X Administrators felt that funding fell far short of the need for family planning services.

- Demand for family planning services increased during the 1980s. Sixty-eight percent of Grantees reported an increased demand for sterilization services; 91 percent felt the demand for STD screening and counseling had increased; 93 percent saw the demand for HIV risk assessment increase during that time as well; an increased demand for contraceptives, particularly new methods, and follow-up of abnormal Pap smears was also noted.

Title X Administrators used many techniques to resolve funding problems during the 1980s including raising more revenues, cutting staff and freezing salaries, and reducing services to clients.

- Seventy-two percent of Title X Administrators increased revenues from other sources such as state monies; 64 percent charged higher client fees; 72 percent sought monies for special family planning services.

- Roughly 70 percent of Title X Grantees reduced or eliminated outreach efforts; 65 percent reduced or eliminated the development of new programs.

- Forty percent of Title X Administrators laid off staff or froze staff salaries; 30 percent closed clinic facilities or halted expansion of new clinic facilities.

- Eighty-five percent reduced the scope of populations targeted, and 36 percent reduced or eliminated services to special populations.

Administrators' greatest source of difficulty in delivering family planning was lack of funding and political controversies surrounding family planning.

- More than 75 percent of Title X Administrators reported that insufficient funding had presented a problem for delivering services since 1990.

- Sixty-one percent felt the "gag rule" hindered their ability to provide services, and roughly 20 percent felt that, in general, Federal, state, and local politics surrounding family planning presented difficulties for service provision.

- Fifty-one percent of Title X Grantees reported that CLIA regulations[1] also presented a burden for family planning service delivery.

Views on How to Improve Services to Low-Income Women

Administrators see re-authorization of Title X, an increase in family planning outreach, and a revision of Title X regulations as important for improving family planning for low-income women.

- Seventy-one percent of Title X administrators suggested that increasing funding for family planning would improve family planning services for low-income women.

- Sixty-five percent noted that increasing outreach efforts and family planning services to population sub-groups would also enhance service delivery for low-income clients.

- Fifty-eight percent recommend a re-examination or revision of Title X service delivery regulations. They perceived a need for the Federal government to rethink the constellation of services mandated under Title X.

- Forty-two percent suggested hiring more staff and providing better salaries for staff, and 30 percent noted that coordination between MCH, Title XX and Medicaid was needed.

Views on Future Family Planning Policy under Health Care Reform

Title X Grantees are ambivalent about the best options for the future of contraceptive services. Many see a more comprehensive approach to family planning delivery and financing as important for the 1990s: However, most worry that such approaches will not have sufficient government and community support; they fear that the focus on family planning could be diluted or lost entirely.

- Between 70 percent and 90 percent of State Administrators saw making family planning services more inclusive of preventive health care, MCH services, or STD services would lead to a more comprehensive package of health care services, and better services for low income women. However, service expansion would require additional revenues, staff training and consistent government and community support.

- Seventy percent saw a third party reimbursement system as providing universal access to health and reproductive health care for all women; it would eliminate the financial burden now borne by publicly-funded family planning providers. However, one may not be able to guarantee that all family planning services or all clients would be covered under such a plan.

- According to 58 percent of Title X Grantees, implementing a Block Grant approach for family planning would lead to greater standardization in the delivery of family planning services. On the

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[1]Clinical Laboratory Improvement Amendments (CLIA) of 1988 imposed strict performance standards and proficiency requirements on laboratories to ensure the accurate reading of Pap tests. CLIA regulations were passed by Congress in response to studies during the mid-1980s that indicated careless misreading of Pap smears. In response to CLIA regulations, laboratories increased the cost for conducting Pap tests which resulted in significantly higher costs to clinics.

other hand, Administrators warned that the logistics and politics of such expansion would be difficult; 93 percent expressed fear that the focus on family planning would be subject to political whims of the state.

Implications for Future Family Planning Service Delivery

- Administrators overwhelmingly expressed the need for more diverse and comprehensive reproductive health services for low-income women. A single location for such services would be ideal, but Administrators recognize that within the current configuration most clinics could not manage such a transition. Additional resources and retraining of staff would be needed to handle the expansion of services and clientele.

- Although Administrators agreed that family planning service provision should expand to address a broad range of reproductive health care needs, feelings are mixed as to how best to configure those services. Combining family planning with maternal and child health, preventive health, or STD services provides for a more balanced approach to reproductive health care. On the other hand, each has the potential to minimize the emphasis on family planning and to reduce access to contraceptive care for some clients.

- Administrators have responded to a reduction in categorical public funding for family planning over the past decade by reducing the scope of services, reducing staff, and increasing the proportion of out-of-pocket costs to clients. Also during this time, client load and complexity of clients' health problems have increased. While our study cannot assess the impact of financial pressures or changing client demand on the quality of care, it can be presumed that at some point, the quality of patient care must begin to suffer. However, family planning service providers are not well positioned to tap into expanded sources of funding for family planning services such as Medicaid. While a few states have a managed care program for Medicaid recipients, most family planning service providers cannot meet the service requirements to be included in a managed care network. Still others face the fact that most of their clients, while low-income, are not Medicaid-eligible and cannot tap Medicaid for reimbursement of services.

- These findings have strong implications for family planning services in the context of health care reform. Health care reform should reduce out-of-pocket expenses of the working poor for health services including family planning and reproductive health care. However, current health care reform packages have three shortcomings that could have important implications for family planning service delivery: 1) Access to free or low-cost contraceptives are not guaranteed; 2) Categorical funding for preventive services such as family planning would be eliminated without a comparable vehicle for replacing such funds; 3) The current family planning network or delivery system could be dismantled thereby reducing or even eliminating access to reproductive health care for many low-income women.

Because family planning is such a small piece of the health care puzzle, it is very easy to overlook the three issues highlighted above. However, many low-income clients may not be adequately served by the new system of care if several criteria are not met. For example, although improvements to the current family planning delivery system may be needed, it possesses many characteristics that are crucial for providing reproductive health care for the poor and special populations, such as: 1) outreach and

education; 2) privacy and confidential services for vulnerable populations such as young clients; 3) free or low-cost contraceptive supplies, and; 4) staff that are skilled in interacting with diverse clientele with a broad range of health needs. Current health care reform proposals must address these criteria in order to ensure universal health care coverage, including reproductive health care, for all populations.

ADMINISTRATOR'S PERSPECTIVES ON SERVICE DELIVERY AND OPTIONS OF FUTURE FAMILY PLANNING SERVICES

INTRODUCTION

The State Survey is the fourth of six reports, commissioned by the Henry J. Kaiser Family Foundation and prepared by the Urban Institute and Child Trends, Inc., that examines the status of publicly funded family planning services in the United States. Taken together, these reports examine how well Federal programs have been able to provide reversible contraceptive services to low-income women and other populations in need. They examine the varied aspects of family planning legislation, funding, service delivery, and service utilization over the past ten years.

In the past decade, Federal support for family planning has diminished. Funding for Title X of the Public Health Service Act was cut, while the Title V and Title XX programs were folded into state block grants. Funding for family planning through these latter programs was not only reduced, but requirements to provide family planning services with these monies were removed. Furthermore, budget cuts were coupled with regulations about service provision, although regulations concerning abortion counseling, the "gag rule"[2], were suspended by the Clinton Administration[3]. Funding and legislative changes were not the only challenges confronting family planning providers in the past decade. During the 1980s, clinics remained a primary source of family planning particularly for low-income populations. Among clinics, Title X funded clinics provided about half of recent visits to clinics in 1980 and 18 percent of all recent family planning visits. Family planning providers were the main source of non-contraceptive

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[2]The "gag rule" is a popular term used to refer to a specific Title X regulation set forth by the Bush Administration in 1988. The regulation stipulated a complete ban on abortion counseling, requirements for the separation of family planning and abortion facilities, and restrictions on lobbying for government support. In February, 1993, the Department of Health and Human Services rescinded the "gag rule" under orders from President Clinton.

[3]See "Legislation and Policy History: Implications for the 1990s" (Burt, M. 1993) for a full description of changes in Federal and state family planning policies

reproductive health services as well as a major source for screening for sexually transmitted diseases and HIV.[4]

Thus, with fewer Title X dollars, family planning providers served more women in a time of increased need for reversible contraceptive services and other reproductive health care. It appears that funding through Medicaid, along with increased state and local revenues and client fees, partially offset cutbacks in Title X monies.[5] The funding mechanisms for family planning services, however, are a patchwork of Federal, state, local and private funds with little continuity across funding mechanisms. More recently, Medicaid has became a dominant public source for all family planning services. According to a recent study by the Alan Guttmacher Institute (Daley and Gold, 1993), Medicaid expenditures for family planning increased dramatically between 1990 and 1992, and accounted for 50 percent of all public spending on family planning services during that time. However, when inflation is taken into account, total public expenditures for contraceptive services decreased since the 1980s. Additional monies provided through the Medicaid program, because it is an entitlement program and not a general support program for family planning support, probably have not completely offset Federal reductions in Title X monies. Furthermore, it is not clear whether states have reduced the scope of services or whether the quality of services has diminished due to fiscal constraints.

In addition, the current Administration is proposing a comprehensive reform of the nation's health care system. While the details concerning coverage and the logistics of implementation remain unclear, it is certain that health care reform will have a substantial impact on the delivery of family planning services in the United States.

Given this history of family planning, it is appropriate to reflect on the status of publicly funded family planning services in the United States, at the state level, as future health care reform policies are

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[4]Levine and Tsoflias (1993) provide a detailed assessment of family planning service utilization.

[5]See "Financing of Family Planning Services" (1993) by Leighton Ku.

debated. To gain a better understanding of service delivery and future family planning options in states across the country, we have conducted a survey of State Administrators about family planning service delivery over the past 10 years, and their perspectives on the future policy context of family planning programs. The main focus of this report is on service delivery via the Title X program and the perspectives of Title X Grantees.

However, descriptions of family planning services provided by non-Title X programs and a discussion of family planning and managed care under Medicaid are also provided.

The main questions addressed in this report are:

- What types of reproductive health care services and reversible contraceptive care did states provide during 1991, and what range of clients did states serve?

- Were there changes in funding and demand for family planning services during the 1980s, and how did states respond to the changes they experienced?

- Have states encountered any problems in delivering family planning services since 1990? What were the main problems states encountered?

- What are the perspectives of state Administrators on future family planning policy options?

This report goes beyond other studies in documenting publicly funded family planning at the state level (Gold and Daley, 1991; Daley and Gold, 1993). These studies have focused on the types of contraceptive services provided and the distribution of family planning expenditures by various state and Federal agencies. However, little is known about how services are managed on the state level, or what issues or difficulties Administrators have encountered in delivering family planning services to the general public. The debate on health care reform makes this type of information particularly important, as it provides insights from state Administrators about the logistics of delivering contraceptive services under a new national health care system.

In addition to this Introduction, this report consists of nine sections:

II. A brief description of study methodology and the respondents interviewed.

III. An overview of family planning service delivery at the state level, including funding streams, how states allocate family planning revenues, reporting requirements, and state regulations on family planning service provision.

IV. A review of family planning services paid for by Title X, MCH, Title XX and State monies in 1991. This section highlights special family planning initiatives and special populations targeted by Title X Grantees.

V. An overview of reversible contraceptive care covered by managed care programs under Medicaid.

VI. A review of changes in funding and demand for Title X services during the 1980s, including how Title X Administrators responded to shifts in funding and client demand.

VII. A brief discussion of the difficulties Title X Administrators encountered in delivering family planning services since 1990 is given, including specific controversies surrounding family planning that they encountered.

VIII. Perspectives of state program Administrators regarding ways to improve services to low-income women are presented.

IX. Title X Administrators' reactions to five policy scenarios for future family planning service delivery are recounted.

X. Implications of the study findings for family planning policy and health care reform are reviewed.

METHODOLOGY

The State Survey was initially designed to obtain interviews with all State Officials who administer public monies for family planning across the United States; the primary focus was on Title X Grantees and the monies they used to deliver reversible contraceptive care. During the initial stages of the project, it became apparent there was a great deal of variability across states in service delivery; a fair amount of overlap in Administrative and fiscal responsibility was also encountered. As a result, modifications to the initial project goals were made. In particular, it was decided to focus exclusively on Title X Grantees and to supplement their responses with information from non-Title X Administrators when data regarding use of monies from public revenues other than Title X were not available. Details concerning the steps taken and modifications made are provided below:

Four steps were used to carry out the State Survey:

- Identification of State Administrators
- Survey Development
- Development of interviewer training materials and training of staff
- Data Preparation and Analysis

Identification of State Officials

State administrators were identified via the Family Life Information Exchange (FLIE), and from membership lists from the Association of Maternal and Child Health Programs (AMCHP), the Association for State Family Planning Administrators (SFPA), and the State Medicaid Directors' Association. The goal was to interview administrators most knowledgeable about family planning service delivery, with a particular focus on Title X family planning services. While each of these lists were quite extensive, two specific challenges were encountered while attempting to identify state respondents.

Out of Date Mailing Lists

Many of the mailing lists obtained were out of date or contained incorrect names, addresses or telephone numbers. In addition, some states had experienced changes in their Title X Grantee status. The FLIE was used as the starting point. Family Planning Regional Program Consultants from the Department of Health and Human Services, who monitor and coordinate family planning activities within the ten regions across the country, were asked to confirm and update the list of Grantees for the states within their respective regions. Updates to the list of non-Title X administrators, with the exception of Medicaid Officials, were made via contacts with Title X administrators during the first wave of interviews at the beginning of the study.

Duplication of Title X and Non-Title X Administrators

Because the lists used to identify state officials originated from different sources, it was often hard to identify instances where the Title X administrator, (particularly officials from State Health Departments), also administered other state programs like the Maternal and Child Health program. To eliminate duplicate names, three specific steps were taken: 1) Each list was put into a database and sorted by state and Administrator type (e.g., MCH, Title X, Title XX, Medicaid). This enabled easy identification of duplicate names, misspelling or inconsistency in names (e.g., William Jones vs. Bill Jones, etc). Duplicates were identified and corrected. Potential duplicates were flagged and follow-up phone calls were made to determine the correct contact person. 2) During preliminary phone calls to schedule interviews, administrators were asked about other programs they administered. Additional duplicates were identified and lists modified. 3) At the interview stage, Title X administrators were provided with a series of questions regarding other sources of family planning monies and other programs they administered. At this final stage, interviewers were able to identify officials who administered more than one state program or monitored more than one pot of public monies for family planning. Virtually all duplicates were identified at steps 1 and 2. Because of the possible duplication, interviews were conducted in stages

within a particular state. For example, Title X grantees were contacted first. Once relevant screening information had been determined, and all Title X surveys conducted, non-Title X Administrators, where necessary, were then contacted and interviewed.

Interview Strategy

The process of compiling an up-to-date list of state officials indicated a good deal of complexity and variability across and within states in terms of family service delivery and funding. For example, it was not uncommon for a Title X Grantee to administer both Title X and non-Title X monies. That is, h/she received monies via the Title X grant but also secured revenues from the MCH program, general state funds, or from the social services block grant program. However, the Title X Grantee typically was not identified as the State Official who managed the respective programs (MCH or Social Services) for the entire state. However, until Title X Grantees were contacted, project staff had no knowledge of the types of programs the official managed, or the range of public monies received for family planning services. In addition, while assessments of publicly funded, state family planning service delivery via all sources of public dollars was important, a primary goal of the State Survey was to assess Title X service delivery and to capture the perspectives of Title X Grantees. Further, in conducting our project, Advisory committee members advised that variability in service delivery across states might make identification and contact of non-Title X administrators both arduous and expensive. Thus, to maximize our efforts, it was decided to focus exclusively on Title X Grantees and to supplement their responses with information from non-Title X Administrators when information regarding use of other monies was not available. Title X Administrators were contacted first to inquire about MCH, Title XX, and state revenues they received for family planning, and the use of those revenues for specific family planning services. If the Title X administrator did not receive any additional public monies for family planning, yet it was determined that other public monies, MCH, Title XX or State funds, were allocated for family planning at the state level, state officials from these respective programs were then contacted. Thus, any information that could not

be obtained from Title X respondents about family planning service delivery was secured by contacting the respective MCH, Title XX, and State administrators. The results presented here, therefore, should not be generalized beyond the population represented.

Medicaid Interviews

The interview strategy, described above, was modified slightly to identify and interview Medicaid Administrators. Because of the possible complexity of state Medicaid programs, telephone calls were made to some of the larger states to determine the difficulty in identifying someone within the Medicaid program who could be knowledgeable about family planning expenditures under Medicaid, and family planning service delivery, particularly under managed care. Our search indicated that interviewing all Medicaid programs across the country would not be an efficient use of human or financial resources. Not only is Medicaid a large program in most states, but family planning is a very small portion of Medicaid expenditures. Thus, few states have someone who specializes in family planning within Medicaid. Rather family planning is subsumed under physician services or primary care services. However, because managed care programs may have important implications for future family planning service delivery, it was decided to contact a subset of Medicaid administrators. The subset was determined by the level of reimbursement for family planning services by each state for FY 1990. States with Medicaid expenditures for family planning that were equal to or higher than the mean expenditures for all states for FY 1990 ($3.7 million) were contacted.[6] The distribution of Medicaid expenditures on family planning presented by Gold and Daley (1991) was used to determine mean Medicaid expenditures and to identify high expenditure states. Medicaid Administrators were contacted specifically to learn more about managed care programs and integration of family planning providers into the managed care network.

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[6]A total of 13 states (25 percent of all states) were identified based on the mean funding criterion. These states include: Arizona, California, Florida, Georgia, Illinois, Louisiana, Michigan, New Jersey, New York, Ohio, Tennessee, Texas, and Wisconsin. Eleven of 13 states (85 percent) were interviewed.

Survey Development

At the time the Kaiser project and the State Survey, in particular, was being conducted, there were several other studies on state-level family planning service delivery that were underway. These activities helped to augment the current effort, but also required attention not to duplicate efforts of other colleagues in the field. For example, the Alan Guttmacher Institute was preparing a survey of family planning agencies. The Association of Maternal and Child Health Programs was assessing cooperative activities between State Title X family planning and maternal and child health programs. The Centers for Disease Control was conducting a study on family planning clients and services for the Association for State Family Planning Administrators. Efforts were made to design questionnaires to augment existing work and not to duplicate or compete with existing research efforts. In addition, several members of organizations conducting other surveys were consulted regularly and reviewed drafts of the survey. The topics included in the survey were determined in the initial proposal to the Kaiser Family Foundation, but were designed to examine state family planning service delivery, funding allocations, changes in state funding and strategies for future family planning policy. Key state officials, along with staff members from organizations with ongoing projects reviewed questionnaires, provided feedback on content areas of the survey and question wording. Questionnaires were revised based on this feedback, sections modified or eliminated. In particular, the survey was modified to focus on administrator perspectives about family planning service delivery and policy.

Because of the differences across states between Title X and non-Title X officials, it was difficult to come up with a standard set of questions that was relevant, and question order or skip pattern that was not too cumbersome to follow in a telephone interview. As a result, two surveys were drafted. One for Title X Grantees and one for non-Title X Administrators. Both surveys included multiple response and open-ended questions. One set of questions was posed to all Administrators on a range of topics, covering.

- Family planning services covered by respective agency revenues for 1991
- Recommendations for improving family planning for low-income women

A specific set of questions was asked of Title X Grantees and Medicaid Administrators.

Title X Grantees were asked about:

- The funding allocations they make to local providers
- Regulations concerning family planning service delivery and staff
- Changes in family planning funding and demand for services over time
- Responses to changes in funding and demand
- Scenarios for future family planning service delivery

Medicaid Administrators were asked about:

- Managed care programs planned or implemented
- Involvement of family planning providers in managed care programs

In this report, answers for all administrators are combined wherever possible, and questions posed to Title X or Medicaid Administrators only are reported and labeled respectively. One should keep in mind however, that the views of non-Title X Administrators are not adequately represented in our study. Summations are based on Administrators' self reports to questions about services provided and reactions to family planning policy. In addition, because the number of administrators per state is small, data are not aggregated to the state level and should not be generalized. State Officials were contacted by telephone between January 1993 and August 1993.

Interviewer Training

Interviews were conducted at Child Trends, Inc., Washington, D.C. under direct supervision. A total of six interviewers administered the telephone survey to state officials across the country. Each interviewer was given a thorough historical review of family planning service delivery and the goals and

objectives of the full study. The interviewer training manual provides a detailed description of the training protocol and is available upon request.

Data Preparation

Surveys were reviewed and edited by the interviewer and the project manager or project director. Questionnaires were reviewed as soon as they were conducted to assure that ambiguities were resolved early in the data collection process and prior to data entry. Codes were developed for open-ended responses. Questionnaires were coded and entered at Child Trends under direct supervision.

Description of Respondents

A total of 75 Title X Grantees were identified from the 1991 FLIE which included 37 state grantees and 38 non-state grantees such as Planned Parenthood affiliates, family planning councils, public hospitals and other community entities. All state Title X Grantees participated in the telephone survey; 35 of the 38 non-state Title X administrators, or 92 percent, were interviewed. The overall response was 72 or 96 percent. An additional 27 non-Title X administrators were contacted to secure information on the use of non-Title X public revenues for family planning in those instances where Title X Grantees did not receive MCH, Title XX or State funds. Thirteen states were identified for the Medicaid portion of the survey, but eleven Medicaid officials (84.6 percent) were interviewed. A total of 109 administrators constitute the full sample of state administrators.[7]

The State Administrators that we interviewed come from a wide range of professional backgrounds and have varied types of expertise. State officials tend to have backgrounds in program administration/management (28 percent), public health (23 percent), or medicine (25 percent). A smaller proportion have backgrounds in the social sciences and social work (13 percent) and education (6 percent).

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[7]One Medicaid Administrator was also the administrator of the Social Services Block Grant Program for the state. The total number of individual respondents is 109. However, percent distributions in a select number of tables may not add to 100.

Administrators also appear to have had long term involvement in family planning. About one-quarter have been in their current position for more than a decade, and nearly 60 percent have been in the field of family planning for more than 10 years.

During their many years of involvement in family planning, respondents have had varied experiences at many levels of service delivery. The majority (60 percent) have spent time as a family planning program administrator at the Federal, state, or local level, however, many have served the field of family planning in other professional capacities as well. One-fifth have been service providers, and another 15 percent have managed or operated clinic services. Some 3 percent have spent time in the area of research or finance/budget management.

FAMILY PLANNING SERVICE DELIVERY AT THE STATE LEVEL

Although the focus of this report is not specifically on sources of revenue for family planning services, the types of funding available for family planning largely determines how family planning services are structured at the state level. It is closely tied with administrative responsibilities, political alliances, and the continuity of service delivery within the state. For the most part, our data regarding the continuity of funding across states are consistent with data compiled by Leighton Ku describing the financing of public family planning services (see Ku 1993). That is, funding at the state level is a patchwork of Federal and state monies given to particular agencies, for the most part, the Title X Grantee.

Table 1 (from Ku 1993) illustrates the primary types of funding available to family planning providers for family planning services -- grants, via Federal and state support, and client fees via insurance and self-payments. However, the illustration in Table 1 is a simplified example of the possible funding streams available for family planning services in a given state. The actual combination of funding mechanisms and the coordination of those streams for overall service delivery on the state level is much more complex. For example, discussions with Administrators suggest that the majority of states have a solid network of family planning clinics that was developed primarily as a result of the initial Family Planning and Population Research Act of 1970, which created the Title X program. However, states, usually state health departments as well as non-state entities, such as regional family planning counsels or Planned Parenthood affiliates, may also apply for funds through Title X; more than one Title X Grantee can exist in a state. Thus, in some states the State is the Title X Grantee. In other states the Grantee(s) is a non-profit organization or group of regional family planning providers; and the state has no participation in the Title X funding mechanism for family planning. Other states have a mixture of state and regional family planning networks. Table 2 shows the proportion of states with state and non-state Title X Grantees. Slightly more than half of all states have a State Title X Grantee Agency that secures

and distributes Title X monies for family planning. One fourth of all states have a non-state Title X Grantee and the state health department does not participate in the Title X program. Roughly one-fifth of all states have a combination of state and non-state Title X Grantees. However, in general we rarely encountered more than two Title X Grantees in a given state, whether state or non-state entity. The exceptions were Pennsylvania and Massachusetts where 4 and 5 non-state Grantees respectively carried the full responsibility for the state's Title X program. Overall, among the 72 Title X Grantees responding, 37 (51 percent) were State grantees; 35 (49 percent) were representatives of regional family planning networks, such as Planned Parenthood and family planning councils.

Table 1. Types of Revenue Source from Family Planning Service Providers

FUNDING SOURCE	USUAL FINANCE MECHANISM *
Federal (Including State Matches)	
Title X Family Planning	Grant to agency/provider. No matching required.
Maternal & Child Health (MCH) Services Block Grant (Title V)	Grant to agency/provider. Requires at least 3 state dollars for every 4 federal dollars.
Title XX Social Services Block Grant	Grant to agency/provider. No match required.
Medicaid	Usually fee-for-service, contingent on client eligibility. Sometimes part of a capitated fee in HMOs. Federal government pays 90 percent of the cost, which is much higher than the usual Medicaid match rate of 50-80 percent.
Other federal (including Medicare, Community Health Center grants, Indian Health Service, etc).	Depends. Excepts for Medicare, these are usually grant funds.
State or Local Government	
Special state appropriations for family planning	Usually granted agency/provider. Sometimes included in other programs, e.g., maternal and child health, community health, etc.
General institutional support (e.g., general funding to public hospitals or local health departments)	Usually funded on a grant-type budget, subject to actual expenditures and revenue from other sources.
Indigent health care programs (usually for General Assistance caseload)	Available in some states. Usually like Medicaid. No federal match.
Private Sources, Including Clients	
Private health insurance	Usually fee-for-service or sometimes part of capitated fees in HMOs and IPAs; based on client's insurance status. Contraceptive services and prescriptions are often not covered under regular private insurance, but are usually included in HMOs. Often include deductibles and copayments.
Self-payments or copayments by clients or donations	Fee-for-service paid by clients. When accompanied by insurance, usually a copayment or deductible. At clinics there may be sliding fee scales, based on income.
Charitable contributions, e.g., United Way or agency fundraising drives	Grant to agency/provider.

Source: Ku, 1993. Financing of Family Planning Services. The Urban Institute, Washington, D.C.

* Providers often receive revenues from multiple sources. There may be intermediate levels between the initial grantee and the final provider of service.

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Table 2: Number and Percent of State and Non-State Title X Grantees

	Number	Percent
State-Only Grantee	27	53.0
Non-State Only Grantee	14	27.4
State & Non-State Grantees	10	19.6
TOTAL	51	100.0

In addition to receiving Title X funds, each Grantee has the option of securing other state, local and private revenues. Title X Grantees may receive monies from the Maternal and Child Health Block Grant (MCH) and the Social Services Block Grant (SSBG on Title XX). They may also receive state revenues earmarked for family planning or special family planning initiatives. Both state and regional Title X Grantees can administer these additional funds. Reimbursement from Medicaid for services rendered to Medicaid recipients is also available. Table 3 shows the breakdown of support that Title X Administrators received from non-Title X sources by Grantee status (State Health Department or non-state Grantee). Both type of grantees received revenues from non-Title X sources, however, clear differences in the combination of non-Title X public dollars that administrators received are evident. For example, 57 percent of State Title X administrators received additional family planning monies from MCH and state revenues. Other combinations of non-Title X monies received by State Title X agencies were minimal. On the other hand, 46 percent of non-state Title X Grantees received no additional public monies at all in 1991. The respective figure for State Title X Grantees was only 8 percent. A smaller proportion of non-state Title X administrators (17 percent) received additional state revenues and a mixture of MCH, State and Title XX monies (11 percent). When the distribution of state and non-state Title X entities across states are considered, the lack of additional public monies has important implications. For example, Missouri, Wyoming, Indiana, Alaska, and the District of Columbia contain non-State Title X administrators who were the only Title X Grantee in the state in 1991. Thus, these states were entirely dependent upon Title X monies to deliver family planning services to low-

income women. Other states, such as New Jersey and Oregon and Texas have one state and one non-state Title X Grantee.

Table 3 : Combination of Non-Title X Public Family Planning Monies Received in 1991, by Title X Grantee Status

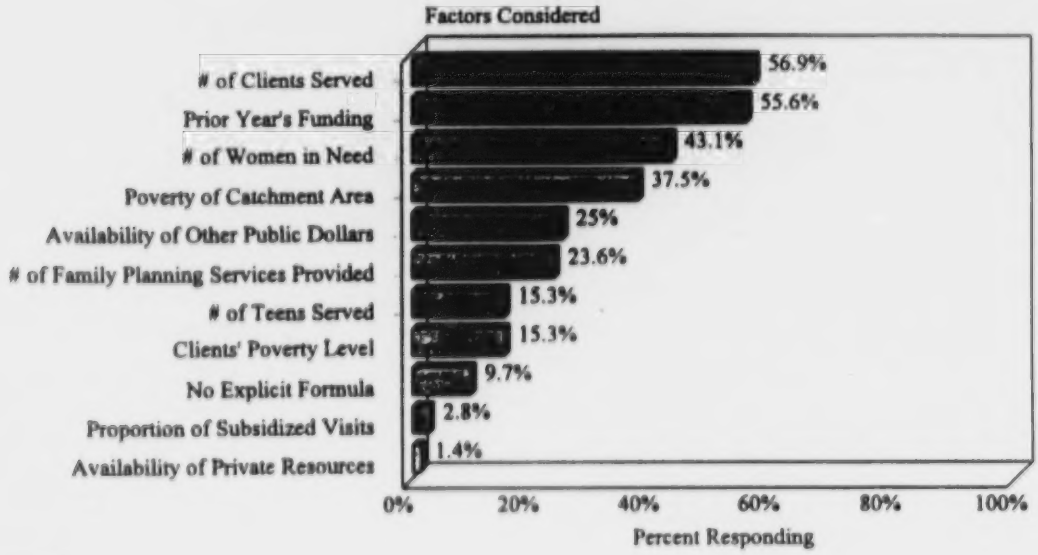
	Title X Grantee Status	
Non-Title X Family Planning Revenues	State Title X Grantee (%)	Non-State Title X Grantee (%)
MCH Only	8.1	8.6
Title XX Only	0.0	5.7
State Funding Only	8.1	17.1
MCH & Title XX	0.0	2.9
MCH & State Funds	56.8	5.7
State & Title XX	8.1	2.9
MCH, State, & Title XX	10.8	11.4
No Additional Public Monies	8.1	45.7

Yet another layer of complexity to family planning service delivery is due to the health care delivery system within which services are provided, and the mechanism for allocating revenues to local providers. Grantees allocate their monies to delegate agencies, such as local jurisdictions or clinics, and services can be provided at a mixture of state and county clinics, outpatient hospital departments, non-profit women's health centers and community-based centers.

We asked Title X Administrators to comment on how Title X monies were allocated or distributed to local family planning sites. We learned that while most states have some set of factors they consider when allocating resources, these factors are not consistent from state to state. Our impression is that while many states employ a specific allocation formula, for the most part allocation of monies is determined by a mixture of objective, usually historic, information and subjective factors.

Figure 1 shows the factors that Title X Grantees consider in making decisions about how to allocate Title X family planning monies to local family planning providers. We note that more than half of Title X Grantees consider the number of clients that have been served previously by delegate agencies, as well as the agency's funding in the prior year, in their decisions regarding the allocation of funds. Forty-three percent look at the number of women in need of contraceptive services[8], and 38 percent consider the level of poverty in the local jurisdiction. Some 24 percent of administrators factor in the number of family planning services provided, and 25 percent consider the availability of other public dollars. Administrators

FIGURE 1:
FACTORS TITLE X ADMINISTRATORS CONSIDER
WHEN ALLOCATING TITLE X FUNDS



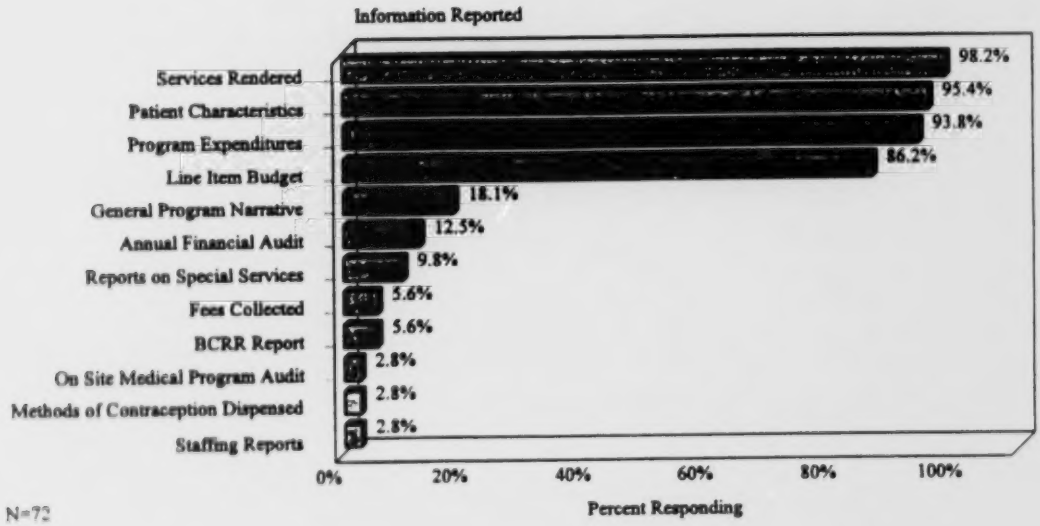
N=72

reported they consider other factors in making decisions about funding allocations which included the poverty level of the individual clients and the number of teens served (15 percent). Nearly 10 percent of all Title X

[8]Women in need of family planning services includes females who are sexually active, not seeking to become pregnant, and not practicing contraception.

administrators report they employ no specific allocation formula in determining how Title X monies should be distributed. To gain a perspective on how Title X Administrators monitor providers' activities, we asked Grantees about the documentation they secure from local providers regarding how Title X funds are spent. Again, there is a good deal of variability across states in what Grantees require local sites to report (see Figure 2). For example, virtually all Grantees (98 percent) ask their delegates to provide information on the types of

FIGURE 2:
INFORMATION REPORTED TO TITLE X GRANTEES
BY LOCAL PROVIDERS



N=72

family planning services rendered, 95 percent request a description of patient characteristics, and 94 percent ask for information on program expenditures. In addition to these reporting requirements, 18 percent request a program narrative with a description of project goals, objectives, and project activities, 10 percent request a description of any special services provided such as HIV services, follow-up of abnormal Pap smears and sterilizations. We see from Figures 1 and 2 that there is a fair amount of variability across states in how

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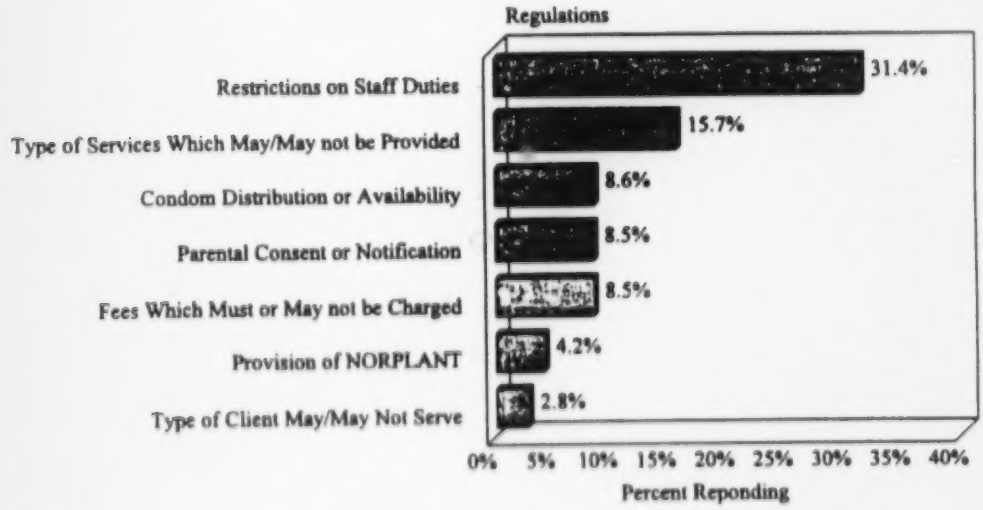
Administrators determine the allocation of Title X monies and the data they require delegate agencies to report. The lack of standardization in reporting requirements and data collection across states has been noted by other researchers assessing family planning service delivery. Both Leighton Ku (1993) of the Urban Institute and Jack Smith (1993) of the Centers for Disease Control report a limited set of standards or protocols for reporting service delivery information and program expenditures for publicly-supported family planning programs across states. This lack of continuity across states makes it difficult to monitor or evaluate national efforts for family planning service delivery.

While many aspects of service delivery and reporting appear to vary across states, on the other hand, Federal regulations regarding the types of services provided and clients served appear to be relatively constant (Figure 3). Less than 10 percent of Grantees report their states or governing agencies have regulations about what clients they can serve, or specific fees they may charge. We do note that 16 percent of Title X Administrators reported restrictions regarding the services they are allowed to provide, but most notably these

FIGURE 3
TITLE X SERVICES WITH RESTRICTIVE REGULATIONS



N=72

restrictions had to do with Federal regulations about abortion and abortion counseling. However, we note that roughly one-third of Grantees reported restrictions about staff duties, training and licensing of staff. Specifically, Grantees reported they had to adhere to regulations about specific duties, licensing of nurse practitioners, and the inability to use nurse practitioners in various service delivery capacities. Since family planning providers often depend upon allied health professionals to deliver a fair amount of reproductive health care in the clinic setting, regulations regarding staffing and restrictions on various duties could pose a important obstacle for reproductive health care delivery.

In summary, we find that the organization of family planning services varies substantively across states. In 27 states (53 percent) the State is the Title X Grantee. In these states, the Grantee also generally receives MCH and state revenues for family planning. In 14 states (27 percent) a non-state agency is the sole participant in the Title X program for that state. In the remaining 10 states (20 percent) multiple Title X Grantees are funded, and 1/4 to 1/3 receive additional family planning funds from MCH, Social Services, and the states. Grantees must, of course, disburse their funds to clinics. The data indicate, again, substantial variation in the process, with previous funding levels and service needs being mentioned most frequently. Administrators usually require clinics to report on expenditures, clients served and services provided, but again little standardization exists across states. Administrators report few restrictive regulations concerning the types of services they deliver, the manner in which those services must be carried out, or the types of clients they may service. They do note sizeable restrictions on staffing and staff duties, particularly the licensing of nurse practitioners and the types of services nurse practitioners may provide.

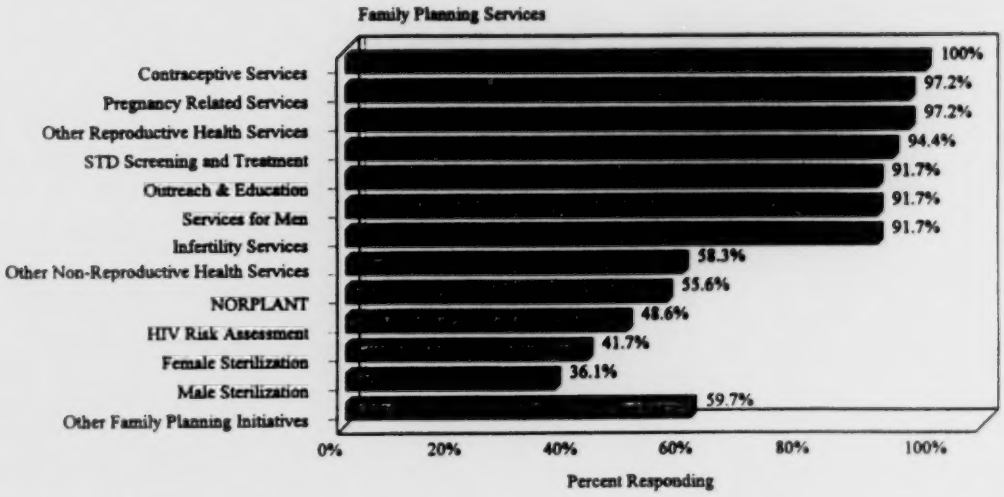
FAMILY PLANNING SERVICES PROVIDED BY PUBLIC MONIES IN 1991

In spite of declining revenues over the past decade, family planning providers continue to deliver a wide range of family planning and reproductive health services, including outreach activities. States are targeting special populations with special needs, such as persons at risk for HIV, as well as providing services to individuals with limited access to reproductive health services, such as rural clients. A similar range of family planning services are paid for by all sources of public funding, although Title X funds seem to be used for HIV screening and counseling more often than other sources of public monies. Furthermore, administrators were less likely to report using public funds for NORPLANT in 1991, including Title X monies.

Use of Title X Monies for Family Planning (Title X Grantees Only)

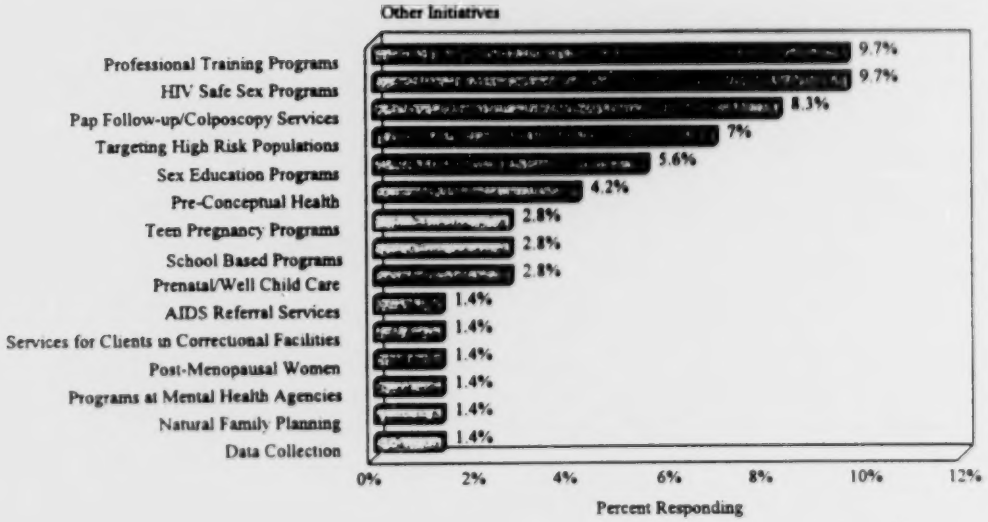
The monies that Title X Grantees received in 1991 provided a host of contraceptive, family planning counseling, and outreach services. Figure 4 shows the proportion of Grantees who used Title X monies for various family planning and related services. While the expected range of services (i.e., contraceptive services and pregnancy related services) are provided, it is clear that these are not the only services states are offering to family planning clients, and that services are not just being provided to female clients. More than 90 percent of Grantees reported that Title X monies provided family planning services to males; 94 percent provided screening for STDs; 97 percent offered other reproductive health services. Nearly 56 percent provided NORPLANT and nearly half provided screening for HIV.

FIGURE 4:
PERCENT OF ADMINISTRATORS REPORTING SERVICES
PAID FOR BY TITLE X IN 1991



N=72

FIGURE 5:
OTHER FAMILY PLANNING INITIATIVES
PROVIDED BY TITLE X FUNDS



N=72

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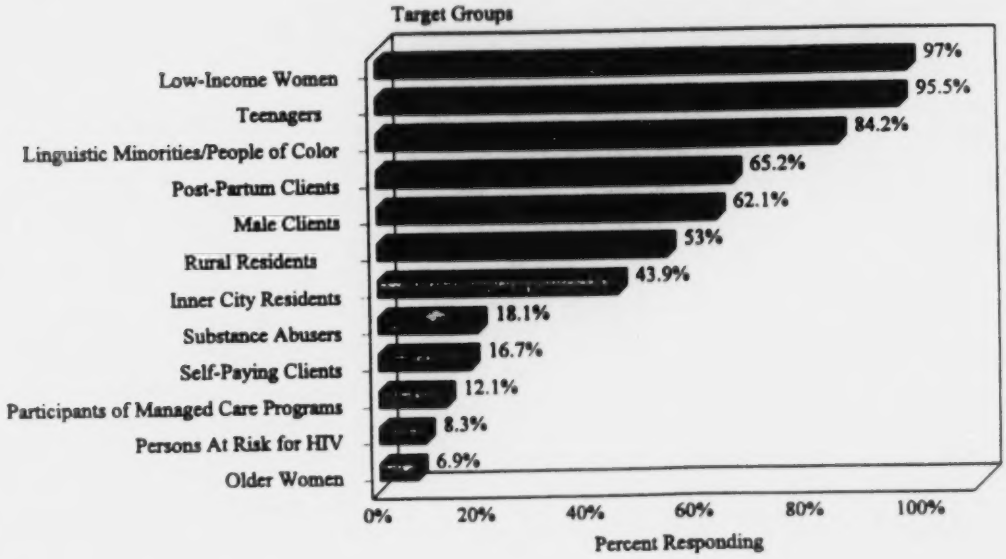
Sixty percent of Title X Administrators stated that they used Title X monies for a host of additional family planning services under their family planning projects as well. These services, shown in Figure 5, included professional training programs (10 percent), HIV safe sex programs (10 percent), teen pregnancy and school initiatives (3 percent), as well as follow-up services for abnormal Pap smears (8 percent).

Clients Targeted for Title X Family Planning Services (Figure 6)

The broad range of services covered under public funds is matched by the broad range of clients targeted by Grantees across the country. Low-income women and teenagers were a prime focus of Title X state family planning administrators. Virtually all Grantees said they focussed their outreach efforts on these two groups of clients during 1991. Eighty-four percent targeted linguistic minorities and clients of color.

Administrators also focused their efforts on other family planning clients as well. For example, nearly two-thirds of Title X Grantees stated they focused their family planning efforts towards post-partum clients and male family planning clients. Efforts were also targeted towards other hard to reach clients such as rural residents (53 percent), and high risk populations such as inner city residents (44 percent), substance abusers (18 percent) and persons at risk for HIV (8 percent). Seven percent of Title X Administrators stated their programs targeted older or post-menopausal women.

FIGURE 6:
PERCENT DISTRIBUTION OF CLIENTS TARGETED FOR
TITLE X FAMILY PLANNING SERVICES IN 1991



N=72

Of the subgroups that Grantees targeted for family planning services during 1991, many were also identified as having limited access to family planning services. Administrators reported that both low-income women and teens had limited access to family planning services; other groups with limited access included rural residents (71 percent), substance abusing women (43 percent), persons of color (43 percent), and older women (9.5 percent) (Figures not shown).

Use of MCH monies for Family Planning (Figure 7)

Fifty-one of our administrators (47 percent) reported using Maternal and Child Health Block Grant funds for family planning services. It appears that MCH, much like Title X, covered a wide range of family planning services, including services to males and family planning outreach. For example, 90 percent reported that they provided pregnancy related services and 84 percent of administrators reported using MCH monies

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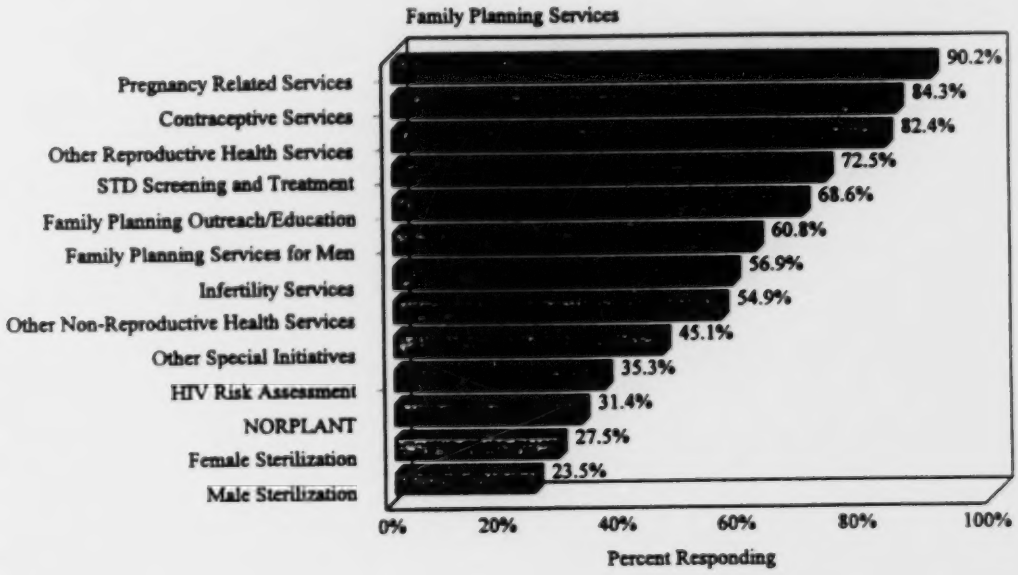
for contraceptive services (excluding NORPLANT); 73 percent of administrators told us that MCH monies went to provide screening and treatment for STDs, and 61 percent said they used MCH funds to cover the cost of family planning services for male clients.

While MCH monies were commonly used to provide the basic array of family planning services, fewer administrators reported using MCH funds for infertility or sterilization services, HIV services or NORPLANT. However, more administrators reported using MCH revenues for infertility services than either NORPLANT or HIV related services. For example, more than half of administrators (57 percent) stated they used MCH monies to provide infertility services, but only 28 percent used these monies for sterilizations for females, 24 percent for sterilizations for males; 31 percent provided NORPLANT, 35 percent used monies to cover risk assessment for HIV.

FIGURE 7:
PERCENT OF ADMINISTRATORS REPORTING SERVICES PAID FOR BY MCH MONIES IN 1991



N=51

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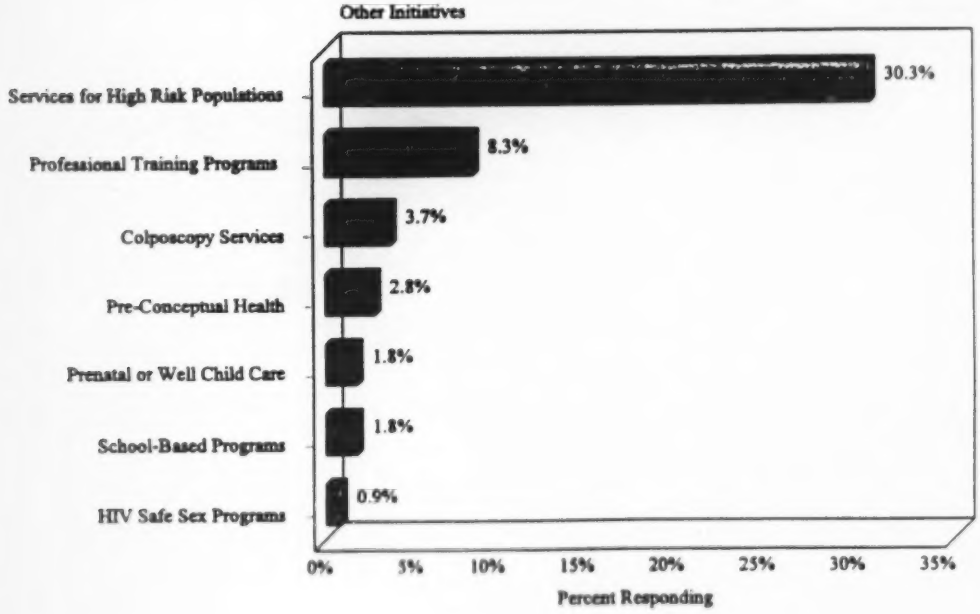
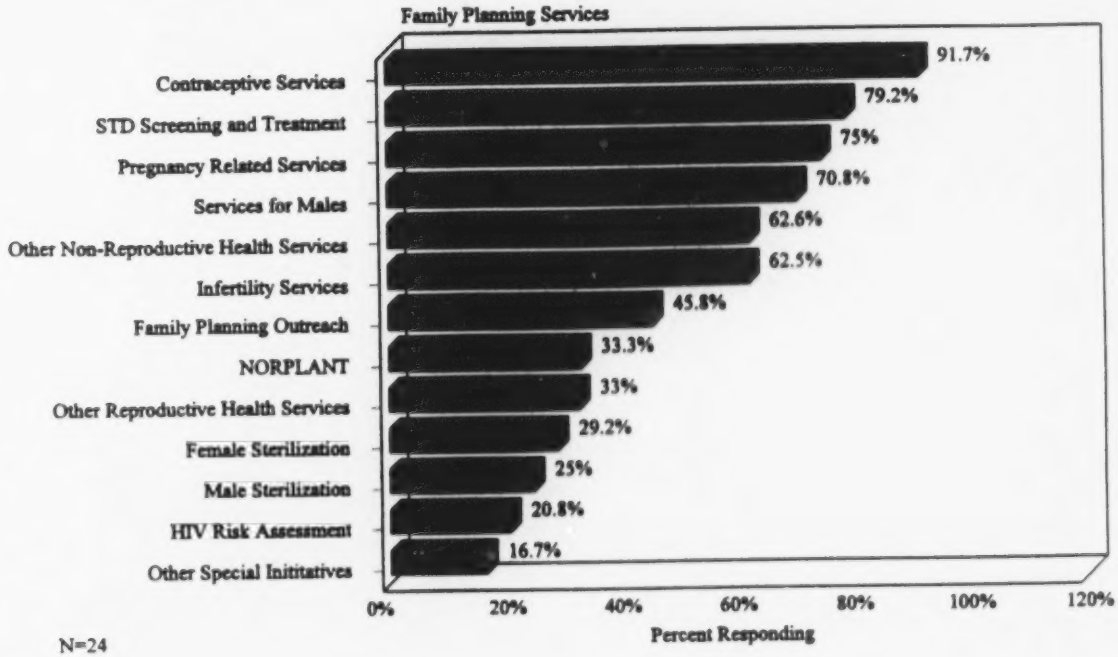
FIGURE 8:
PERCENT OF ADMINISTRATORS REPORTING
OTHER INITIATIVES PROVIDED BY MCH FUNDS IN 1991



N=51

MCH revenues were also used to cover special family planning initiatives (Figure 8). These additional services primarily included outreach services for high risk populations (30 percent), although other special activities were provided such as professional training programs (8 percent), colposcopy and follow-up services for abnormal pap smears, (4 percent) and pre-conceptual health services (3 percent).

FIGURE 9:
SERVICES PAID FOR BY TITLE XX IN 1991



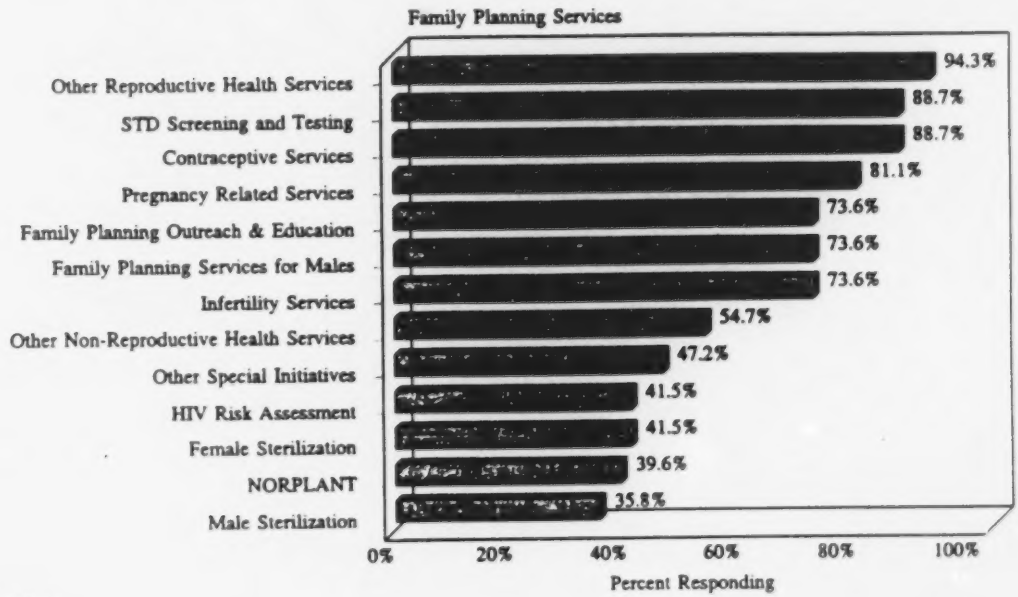
Use of Title XX Monies for Family Planning Services (Figure 9)

Fewer Administrators reported using Title XX revenues for family planning than either Title X or MCH monies. Twenty-four administrators (22 percent) reported using Title XX monies for family planning services. In addition, these monies appeared to be dispersed primarily for more traditional family planning activities, including contraceptive services (92 percent) and pregnancy related services (75 percent). However, nearly 80 percent of Administrators reported using Title XX monies to cover costs for STD screening and treatment. In addition, 71 percent of those who spent any Title XX monies on family planning used these revenues to cover family planning services for men, which included primarily the distribution of condoms and general family planning counseling. Fewer administrators reported using their Title XX monies to provide NORPLANT (33 percent), HIV screening (21 percent) and other special family planning initiatives (17 percent).

Use of State Funds for Family Planning Services (Figure 10)

Previous studies have suggested that State revenues have been used to offset the decline in Federal revenues for family planning (Ku, 1993; Gold and Daley, 1991). Indeed, nearly half of all Administrators reported using state revenues for family planning services. Among those receiving any state funds for family planning administrators frequently reported using State revenues to provide other reproductive health services, such as colposcopy screening (94 percent), contraceptive services (89 percent), and pregnancy related services (81 percent). State revenues were also used to cover costs for STD screening

FIGURE 10:
PERCENT OF ADMINISTRATORS REPORTING
FAMILY PLANNING SERVICES PAID FOR BY STATE FUNDS IN 1991



N=53

and testing (89 percent). Nearly 75 percent of administrators reported using State revenues to provide family planning services to male clients. On the other hand, HIV related services, sterilizations, and NORPLANT were the services least often covered by State revenues. About 40 percent of Administrators reported they used State monies to provide NORPLANT to family planning clients, and 42 percent told us they used state

funding for female sterilizations and HIV risk assessment; 36 percent said that State monies covered sterilizations for male clients.

Although states have been picking up some of the slack created by limited Federal revenues, it is not clear that states have contributed their family planning monies primarily for this reason. In fact, Grantees told us that their state contributes monies to family planning because it recognizes the need for providing publicly funded family planning services, particularly to minimize the number of unwanted pregnancies and early births to teens. In fact, 62 percent of Grantees told us that their state initiated its contributions to family planning for this reason, while only 15 percent believed their state contributes funds as a response to limited Federal funding for family planning; 31 percent indicate state monies are contributed because family planning is part of a larger state initiative (figures not shown).

Our assessments of family planning service delivery at the state level indicate that while virtually all family planning sources allocate monies toward contraception and pregnancy-related services, monies were also expended on an array of additional services as well. Nearly all Administrators reported spending Title X funds on males and STD screening. Almost as many Administrators reported spending state, Title XX, and MCH funds for these purposes. Fifty-six percent of Administrators spend Title X monies for NORPLANT, higher than the 31-40 percent reported for the other funding streams. The broad range of services is matched by a broad range of clients targeted for services. Low income women and teens were almost universally targeted, but six in ten Administrators reported targeting post-partum women, men, and Spanish-speaking women. Relatively few Administrators targeted outreach to self-paying clients or individuals in managed care programs.

FAMILY PLANNING AND MANAGED CARE UNDER MEDICAID

With rising health care costs and reductions in the amount of Federally subsidized family planning funding in recent years, state leaders have been searching for various alternatives to delivering primary care and family planning to low-income clients. These alternatives, which primarily include health maintenance organizations (HMOs), challenge the traditional fee-for-service model of primary health care in this country. In particular, state Medicaid programs have been investigating and developing ways to implement various managed care strategies using HMO systems of delivering care. In some states, family planning agencies are an integral part of that managed care network, providing selected family planning services through subcontractual agreements, or providing a full range of family planning services as full members of the provider network (Wunsch and Aved, 1987).

The scenario described above, however, may not be played out in the same way in all states across the country. Not every state has a managed care program in place, nor are family planning providers an integral part of that managed care delivery system, if indeed, one does exist. Furthermore, as this strategy gains acceptance as a means for controlling health care costs, it will have implications for family planning providers and the integrity of the family planning service delivery network.

To learn more about the status of managed care networks under state Medicaid programs, we asked Medicaid Administrators from 11 states to comment on the efforts within their states towards a managed system of care, and the extent to which family planning providers were a part, or were being considered as part of the managed care network. We spoke with officials from Medicaid offices in Arizona, California, Florida, Georgia, Illinois, Louisiana, Michigan, New York, Ohio, Tennessee, and Texas. Highlights of our discussions with them are described below.

All the states we contacted had some type of a managed care program in place or were developing a plan for managed care. Five states reported a primary care case management strategy and 7 sponsored services via an HMO or an Independent Practice Association (IPA) strategy. Three states said they were also

developing other programs or that pilot testing of programs was underway.

Administrators reporting about managed care programs currently in place stated that efforts were generally targeted toward Medicaid recipients, AFDC recipients, or pregnant women with small children. On the other hand, pilot programs were being designed to provide services for special populations, including the mentally ill, persons with AIDS, and teens at risk of pregnancy. Family planning providers are not fully integrated into this system of health care delivery, either because they are not allowed, or because of stipulations about access of physicians and clinic hours preclude their participation. For example, three Medicaid administrators reported that family planning providers in their state did not participate at all in the managed system. Two Medicaid officials reported that in their state, family planning providers are allowed to participate, but that the specific requirements for participation -- availability of a physician for a minimum of 20 hours per week, and clinic operation of specific hours during the week -- typically make family planning providers ineligible. On the other hand, one Medicaid official acknowledged that his/her state allows full participation of family planning providers via a subcontract to the state for family planning services; one other respondent noted that a plan was being developed to include family planning providers in the managed care system.

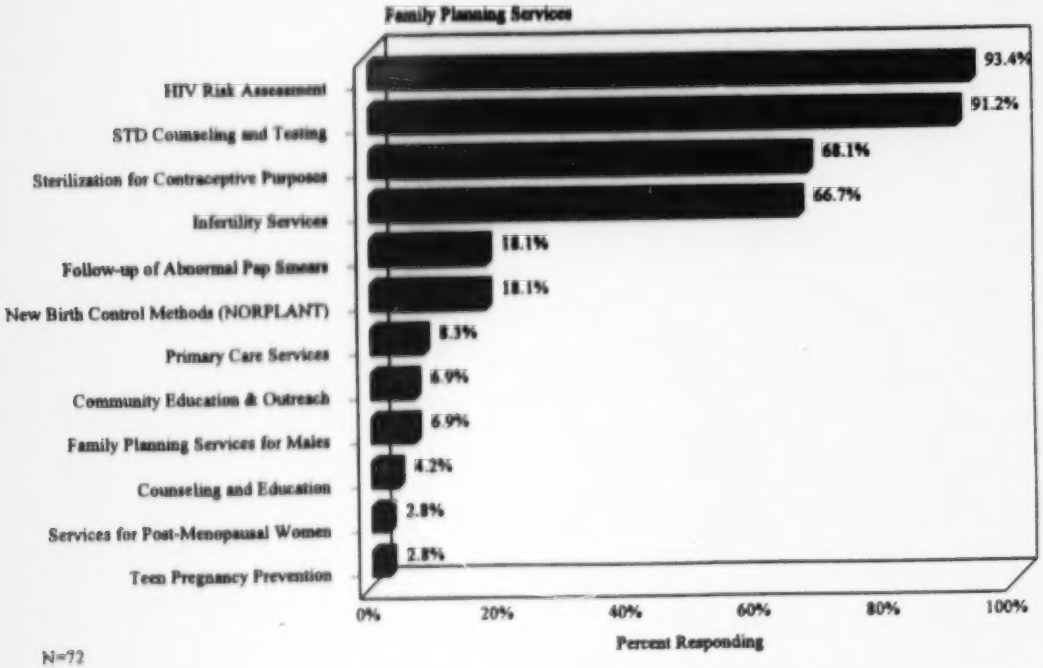
CHANGES IN TITLE X FUNDING AND THE DEMAND FOR TITLE X SERVICES DURING THE 1980s

It is evident that Federal revenues for family planning declined over the 1980s, while client demand for special reproductive health services, such as HIV and STD screening and testing, and general primary health care, increased during this time. The obvious result is a greater need for services in an atmosphere of greater financial and human constraints. What is not evident, however, is the magnitude of this mis-match, the extent to which that scenario is played out in individual states across the country, and, more importantly, how states responded to these pressures.

Discussions with Title X Grantees indicate that, indeed, the vast majority of states experienced declines in Federal support for family planning during 1980s, net of inflation. Roughly 88 percent of Title X administrators noted a decline in Title X funding between 1980 and 1989. Just under 3 percent reported that their Title X funding increased during the 1980s, and 7 percent say they saw their Title X dollars remain constant over that 10 year period. Moreover, even among the few who saw their monies increase or remain stable, virtually all Grantees believed their funding was insufficient to meet their service demand needs. Ninety-eight percent of Title X Administrators said that funding generally fell short of service needs; in fact, 85 percent of all administrators felt that funding fell far short of the need for family planning services.

Equally apparent from our data (Figure 11) is an increased demand for family planning services during the 1980s. In particular, 93 percent saw the demand for HIV counseling and risk assessment increase during that time, while 91 percent of Grantees stated that there was an increased need for STD counseling and testing. Sixty-seven percent felt that requests for infertility services had increased during the 1980s and demand for sterilization services (68 percent) also rose.

FIGURE 11:
TITLE X FAMILY PLANNING SERVICES
FOR WHICH DEMAND INCREASED BETWEEN 1980 AND 1989



N=72

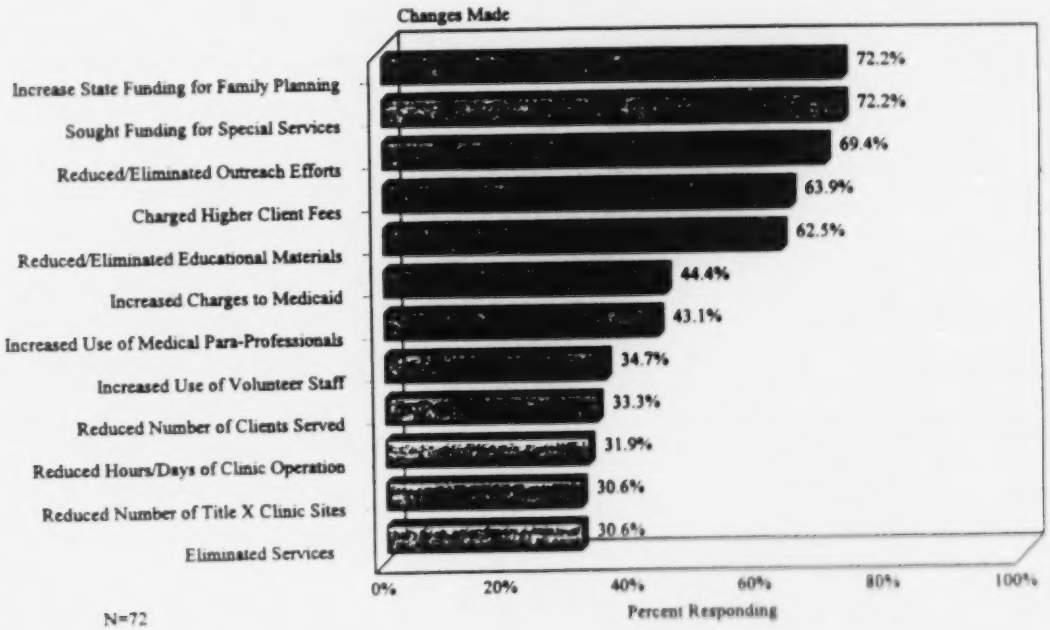
Other services also increased during this time, although not to the same extent as those services just described. For example, Grantees reported that clients presented an increased demand for follow-up and referrals for abnormal Pap smears and increased demand for new birth control methods such as NORPLANT (18 percent). Demand for counseling and education, and requests for family planning services for men also increased during the 1980s.

A prime question according Leighton Ku's report on the financing of family planning services (1993) is how states actually provided more family planning services with fewer funds during the 1980s. What could not be determined from his review, however, is whether states offered fewer services to compensate for limited resources, or whether the quality of family planning services has generally suffered due their efforts to minimize cost.

Although we are unable to document whether the quality of family planning care has been affected, our data do suggest that states have made a conscious effort to become more efficient in delivering care to their

family planning clients and that some services have been cut. In fact, Figure 12 illustrates that states responded to fiscal challenges in a variety of ways -- by increasing revenues from other sources such as state monies (72 percent), by seeking monies for special family planning initiatives (72 percent), and by charging higher client fees (64 percent). States also reduced the scope of or eliminated various services they provided. For example, roughly 70 percent of Grantees stated they reduced or eliminated outreach efforts; sixty-three percent reduced the amount or the scope of education materials they produced; 31 percent stopped providing various types of family planning services; and 31 percent reduced the number of clinic facilities or halted expansion of new sites.

FIGURE 12:
CHANGES TITLE X ADMINISTRATORS MADE
IN REPONSE TO A LACK OF TITLE X FUNDING



Some Grantees also told us that they opted to lay off staff or to freeze staff salaries (40 percent), or eliminated services to special populations (36 percent) such as projects for female inmates (Figures not shown).

In sum, virtually all Administrators report declines in funding and increased demand for services. Moreover, the data provide no evidence of greater or easier access to family planning services during the past decade. The effect of reductions in outreach, staff layoffs and holding the line on salaries, and closing facilities or minimizing expansion seems likely to have reduced the availability, accessibility or quality of services in the 1980s.

PROBLEMS ENCOUNTERED BY TITLE X ADMINISTRATORS IN DELIVERING FAMILY PLANNING SERVICES AND CONTROVERSIES SURROUNDING FAMILY PLANNING

The context of family planning service delivery during the 1980s was a mixture of limited financial resources and political and regulatory constraints. Government support for family planning waned, and providers were confronted with new challenges such as restrictions on services to minors and restrictions on abortion counseling. Thus, in addition to funding constraints, providers were frequently forced to deliver services in a context of limited social and political support. A new decade has brought a new Federal Administration, but the country still has not resolved its ambivalence and disagreements surrounding the provision of reproductive health services to low-income and young women.

We asked Administrators what types of problems states had encountered in the 1990s. Figure 13 illustrates how Grantees responded to that particular question. The graph indicates that while limited funding remains a source of concern for service delivery for most Grantees, it appears that just as many problems encountered by Grantees since 1990 have to do with Federal policies concerning restrictions or protocols for the provision of services. For example, we note that insufficient funds or reductions in the allocation of funds tops the list of problems for our Grantees. For more than 3/4 of Grantees, insufficient funding has presented a problem for delivering services since 1990. Sixty-one percent of Grantees felt the "gag rule" and other anti-abortion issues hindered their ability to provide services; 51 percent reported that increased costs resulting from the Clinical Laboratory Improvement Amendments (CLIA)[9] also presented problems for service delivery. This confirms other reports that suggest the increased financial burden on clinics resulting from higher fees charged by laboratories can be quite substantial. It is estimated that in some states, reproductive health providers paid $200,000 to $300,000 more for Pap tests in 1991 than in 1990 (Donovan, 1991).

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[9]Clinical Laboratory Improvement Amendments (CLIA) of 1988 imposed strict performance standards and proficiency requirements on laboratories to ensure the accurate reading of Pap tests. CLIA regulations were passed by Congress in response to studies during the mid-1980s that indicated careless misreading of Pap smears. In response to CLIA regulations, laboratories increased the cost for conducting Pap tests which resulted in significantly higher costs to clinics.

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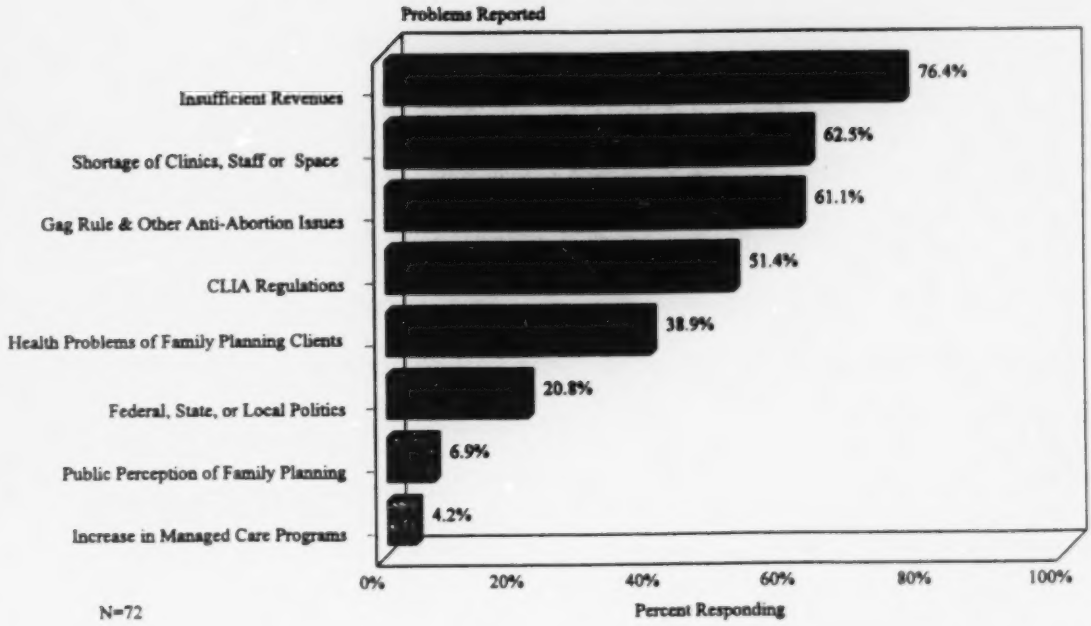
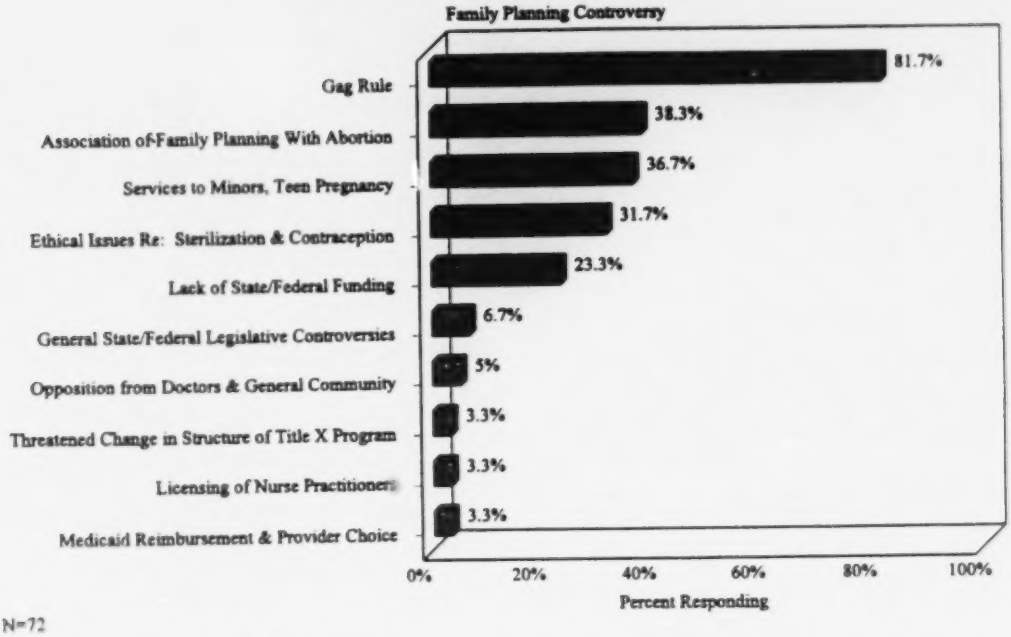
FIGURE 13:
PROBLEMS DELIVERING TITLE X SERVICES SINCE 1990
IN ORDER OF PERCENT RESPONDING



Twenty-one percent of administrators felt that, in general, dealing with Federal, state, and local politics surrounding family planning presented difficulties for service provision in their state.

In terms of specific controversies since the beginning of this decade, the "gag rule" was, by far, the greatest controversy for most Title X Grantees, according to distributions in Figure 14. Eighty-two percent reported that they experienced numerous difficulties surrounding this issue. Many Grantees informed us that it took substantial staff effort (in a time when staff resources were limited and client demand high) to keep up with pending legislation and interpretation of the regulations regarding the provider/client relationship.

FIGURE 14:
FAMILY PLANNING CONTROVERSY EXPERIENCED BY
TITLE X ADMINISTRATORS SINCE 1990



N=72

In addition to confronting the "gag rule", Grantees experienced controversies surrounding the association of Title X and family planning with abortion. Thirty-eight percent of Grantees saw the abortion issue as a controversy for their state, and 37 percent report that the provision of services to minors and teenage pregnancy were a source of controversy for family planning.

Although the gag rule has been rescinded by President Clinton, Title X Grantees still confront many obstacles that affect of service provision. Regulations about laboratory procedures and universal precautions still raise costs, and the general climate with respect to abortion funding and the provision of services for youth remains politically charged. Thus, limited funding, increased demand for services, and time diverted to address on-going controversies have combined in ways that seem very likely to have undermined the delivery of services.

IMPROVING THE DELIVERY OF PUBLICLY-FUNDING FAMILY PLANNING SERVICES: POLICY OPTIONS FOR THE 1990s

The reports of state-level family planning Administrators indicate that many aspects of service delivery could be targeted for improvement. While states continue to deliver family planning services to clients with an increased demand for care, they do so within a context of limited financial and human resources and diminished public and political support. The network of providers, funding mechanisms, reporting requirements and data collection efforts all differ across states. Such heterogeneity allows states a great deal of flexibility, but also limits any efforts for monitoring or assuring standards for delivering or financing care across the country. In this section of our report, we highlight Administrators' perspectives on how to improve the delivery of family planning services for low-income women. We also present Title X Administrators' reactions to five specific scenarios for family planning service delivery:

- Expanding family planning to include preventive care services;
- Integrating Title X family planning with MCH services;
- Integrating Title X family planning with STD services;
- Using a national third party reimbursement system for family planning; and
- Using a block grant approach to finance family planning:

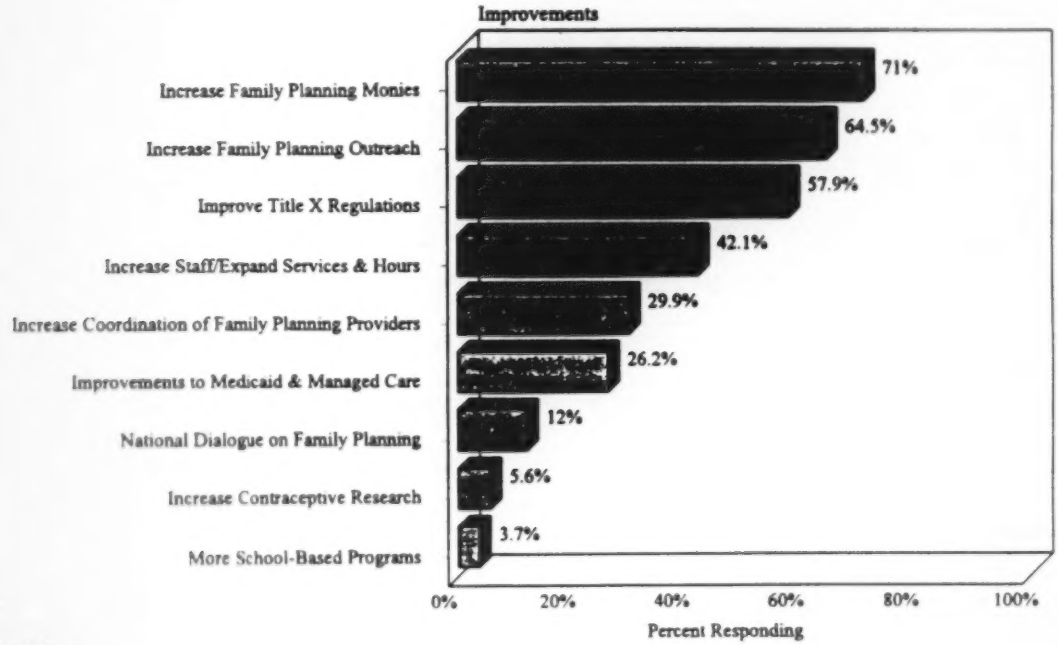
In soliciting the perspectives of Title X Administrators, we asked them to explore the advantages and disadvantages of various approaches to organizing the delivery of family planning services. Interestingly, their responses are quite uniform, in that they generally acknowledge the need for a more comprehensive approach toward family planning service delivery. Grantees also indicate that such approaches require additional funding, retraining of staff, and above all, active and consistent support from the Federal and state governments and the general public. Indeed these last elements may be critical, in the long run, for improving the delivery of publicly-supported family planning services.

How Can the Delivery of Family Planning Services to Low-Income Women be Improved?

Administrators provided us with many suggestions about how to improve the delivery of family planning for low-income clients. Figure 15 presents the various responses and the proportion of state officials who provided us with those suggestions. The one suggestion offered by the majority of Administrators was to increase funding for family planning, offered by 71 percent of all Administrators. Given the general reduction in Federal funds and the increase in demand for family planning services, it is not surprising that Administrators see this as a prime vehicle for improving service delivery. However, officials also noted that increasing outreach efforts and special family planning services to population sub-groups would also greatly enhance services to low-income clients. Nearly two-thirds of state officials provided this suggestion.

FIGURE 15:

ADMINISTRATORS' SUGGESTIONS ON HOW TO IMPROVE FAMILY PLANNING FOR THE POOR



N=109

In addition to increasing revenues and service outreach efforts, Administrators noted that Federal

regulations, specifically regulations under the Title X program, should be re-examined and improved. In fact, nearly 60 percent of respondents recommended that the Federal government think more critically about the constellation of services mandated under Title X and whether all services need to be provided to all family planning clients. Many informed us that their delegate agencies were obligated to provide an array of basic and screening services to family planning clients, even if it was determined that a client did not present a need for such services. Such revisions of Title X required services be coupled with a review of existing reporting requirements, regulations, and data collection strategies.

Because of the increased demands on staff providers in general, Administrators also felt that being able to hire more staff and to expand services and hours of operation would be an important change in service delivery; attracting more qualified personnel would provide a big boost for family planning services. Forty-two percent of Administrators noted that more staff and better salaries for staff would greatly enhance both providers' capacity to serve and staff morale. This would reduce patient loads and provide greater flexibility in providing care to family planning clients.

A little more than one-quarter of state officials suggested that improvements to Medicaid, specifically expansion of Medicaid eligibility, and changes in managed care under Medicaid, would enhance family planning services for low-income women. Increasing coordination of family planning under Title X with other state programs, such as MCH, Title XX and Medicaid, would also be a valuable way to improve family planning services, with 30 percent of Administrators offering that particular recommendation. Roughly 5 percent of State officials suggested that more contraceptive research was needed in order to provide a wider range of family planning options to clients; officials also recommended that more school-based programs be provided to increase outreach efforts to teens.

Policy Options for the 1990s

As we look toward the future of family planning service delivery, particularly in light of the current discussion on health care reform, it is important to investigate the logistics of implementing different service delivery strategies across the country. Because states, characteristics of communities, health needs, and existing service delivery networks differ, some strategies may be appropriate while others are inappropriate. It is important to take stock of how different strategies for family planning service delivery may be received by state Administrators and their insights regarding the possible successes or failures of these varied approaches to delivering care.

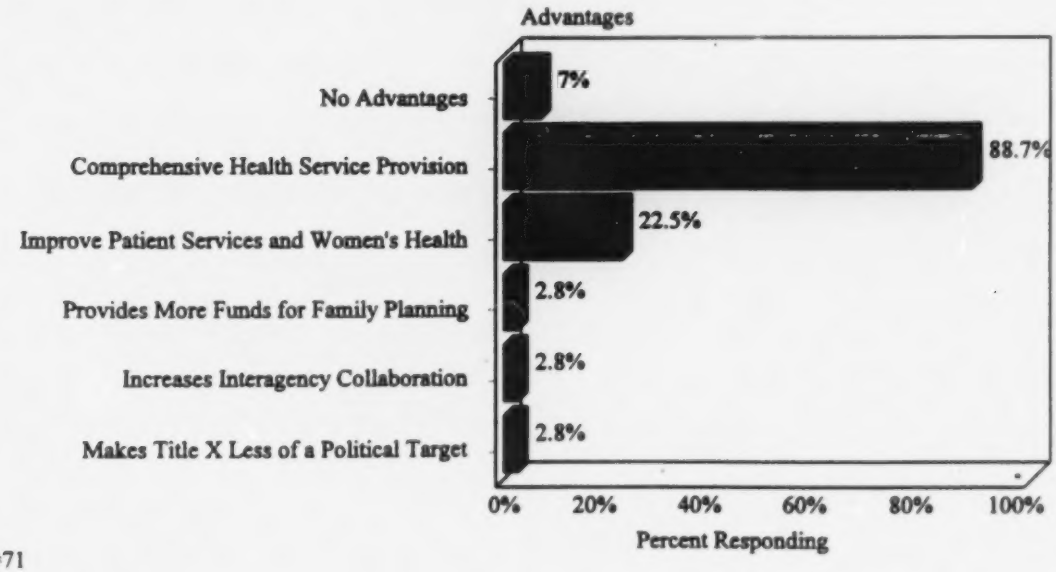
Should Family Planning be Expanded to Include Preventive Care Services?

The past decade has witnessed an increase in STDs, HIV, and other reproductive health and general health problems. As the United States does not have a national network of general primary health care providers that are accessible to low-income women, family planning clinics are often the first and only source of health care (Donovan, 1991; Laurie, 1990). One option for family planning providers is to expand the scope of services they currently provide to include a broader range of preventive and primary health care activities. As many providers currently receive clients in need of preventive and primary health care, this "one-stop-shopping" may be a more efficient way of providing better health care for low-income populations.

Grantees overwhelmingly agreed with this line of reasoning (see Figure 16). In fact, nearly 90 percent of Grantees felt that an advantage of expanding family planning services to include preventive health services is the fact that this change would lead to more comprehensive health care for low-income clients and would reduce the duplication of services currently provided. Service expansion would also improve the quality of services for patients and improve women's health overall (23 percent). Furthermore, in the view of some Administrators, this approach would help to provide additional sources of revenue for family planning, would increase collaboration between family planning agencies and other health care providers, and would reduce the political focus on Title X.

FIGURE 16:

ADMINISTRATORS' PERSPECTIVES ON THE ADVANTAGES OF EXPANDING FAMILY PLANNING TO INCLUDE PREVENTIVE CARE SERVICES

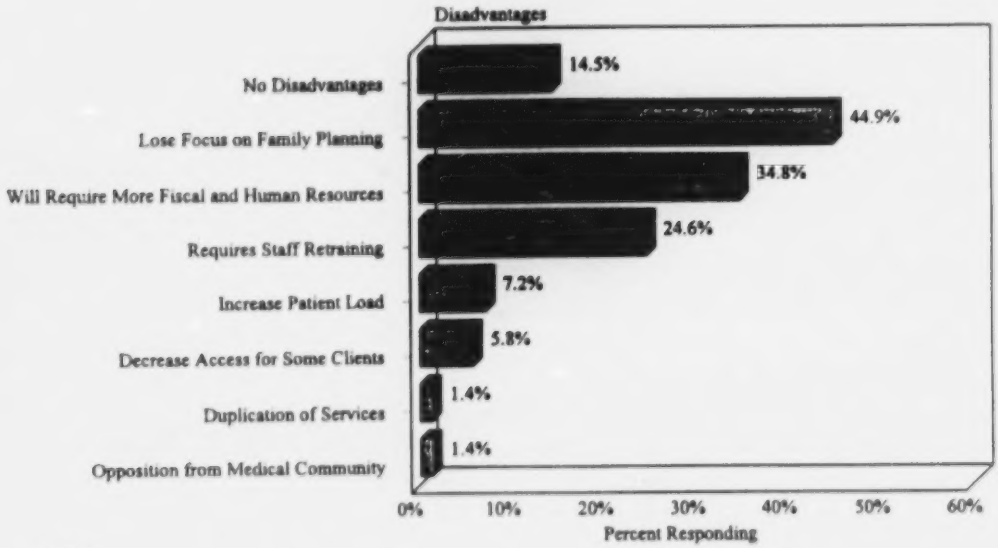


N=71

The expansion strategy is not without negative consequences, however. Grantees were quick to remind us that broadening the scope of services provided by family planning providers could also decrease family planning monies and reduce the direct focus on family planning (see Figure 17). In fact, 45 percent of Grantees feared that the "expansion" approach would generate such an effect. Thirty-five percent reminded us that expanding services naturally required an expansion of funds. Providing more services would cost more money, at least in the short run and would require additional financial and staff resources. In addition, one-quarter of Title X administrators told us that under this approach staff would need to be trained, or retrained, to provide such services and to take a broader primary health care approach to service delivery. Roughly 7 percent of Grantees noted that this strategy may lead to an increase in the number of clients and might increase providers' patient load; it may also reduce access to family planning for some clients (6 percent). A few Grantees worried that the expansion approach may lead to possible duplication of services that are provided

by primary care providers, and that the medical community may not be fully supportive of this approach which could pose obstacles or create new controversies.

FIGURE 17:
ADMINISTRATORS' PERSPECTIVES ON THE DISADVANTAGES OF
EXPANDING FAMILY PLANNING TO INCLUDE PREVENTIVE CARE SERVICES



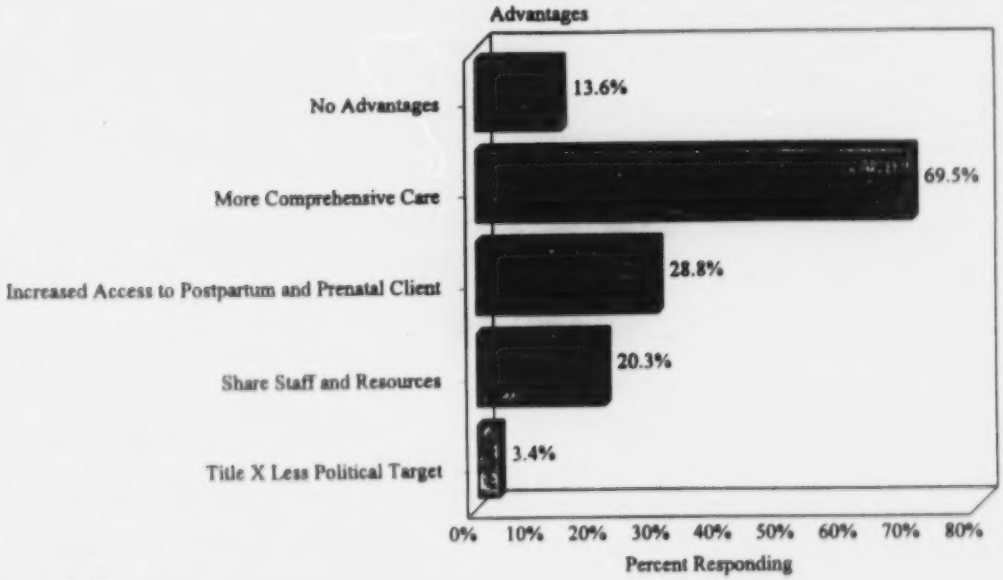
N=72

Should Family Planning be Integrated with Maternal and Child Health Services?

Another option for family planning providers is to integrate their services with those delivered under the auspices of the Maternal and Child Health program. A number of states currently employ this approach and still maintain a high level of involvement in family planning. Figure 18 shows that the majority of Grantees (70 percent) perceive this approach as a means for providing more comprehensive health care to women. Roughly 30 percent of Grantees feel this approach would give providers better access to post-partum women and pregnant women and would offer these women better access to family planning providers. One-fifth of Title X officials saw this approach as a way to share staff and resources with maternal and child health provider agencies. About 3 percent of Grantees felt the merging of the two programs would enhance their

lobbying efforts for family planning and preventive care and make Title X less of a political target for budget cuts or legislative controversies.

FIGURE 18:
ADMINISTRATORS' PERSPECTIVES ON THE ADVANTAGES OF
INTEGRATING FAMILY PLANNING WITH MATERNAL AND CHILD HEALTH SERVICES

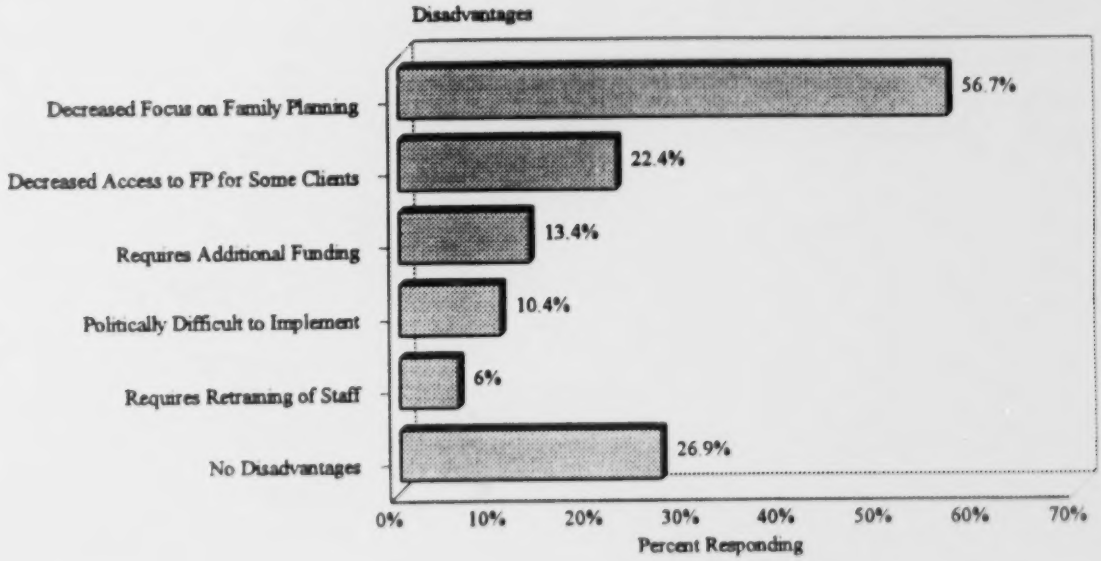


N=59

However, integrating with MCH also presents problems for many Grantees. We note that in Figure 19, nearly 57 percent were concerned that the integration strategy would diminish the focus or the emphasis placed on family planning. In addition, as the two programs operate under different models of care, combining forces may make family planning services less accessible to some clients. About 22 percent of Grantees felt that mixing MCH and family planning services would decrease access to family planning among special populations such as teens and women at risk for STDs or HIV who are not typically part of the MCH clientele. Conversely, MCH clients may not be comfortable receiving their care with such a mixture of health clients.

As with the expansion approach, Grantees were concerned about the need for increased funding (13 percent) and the need to provide additional support to retrain staff (6 percent). They also felt that such an integration would be politically and administratively difficult to implement. Approximately 10 percent of Grantees had questions about who would manage such a program and who would be responsible for monitoring and allocating program funds. However, 27 percent saw no disadvantage at all to this approach.

FIGURE 19:
ADMINISTRATORS' PERSPECTIVES ON THE DISADVANTAGES OF
INTEGRATING FAMILY PLANNING WITH MATERNAL AND CHILD HEALTH SERVICES



N=67

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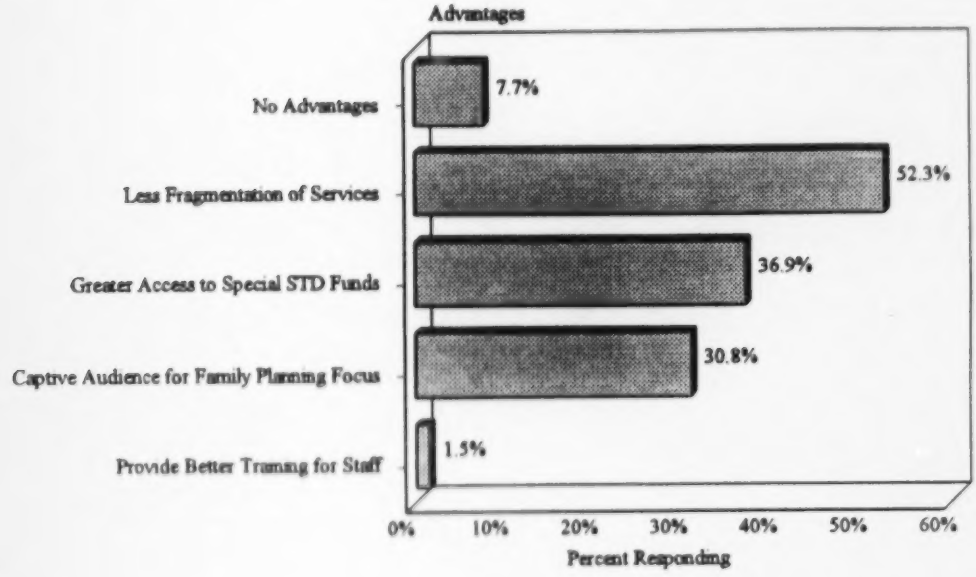
Should Family Planning Services be Integrated with Sexually Transmitted Disease Services?

Our description of family planning services delivered at the state level indicates that providers are offering an increased number of STD related services to family planning clients. Joining forces with STD service providers may be another means for enhancing service delivery for low-income women. Many of our Grantees responded favorably to this approach, as illustrated by Figure 20. Fifty-two percent felt this strategy would

FIGURE 20:
ADMINISTRATORS' PERSPECTIVES ON THE ADVANTAGES OF INTEGRATING FAMILY PLANNING WITH STD SERVICES

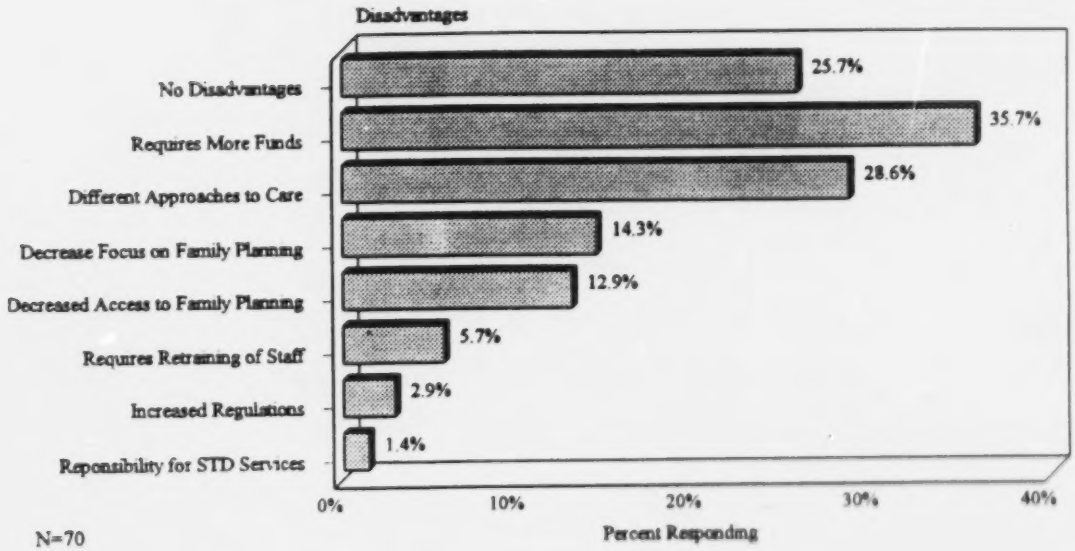


N=65

provide a unified health effort, and less fragmentation of reproductive health services. Roughly 37 percent saw this as an opportunity to gain greater access to special STD funding which could offset much of the cost of STD service provision currently offered by providers. In addition, 31 percent saw this approach as an opportunity to gain better access to an important target group they now serve.

As with the other strategies we presented, Grantees saw many disadvantages to this approach to service delivery as well (see Figure 21). Again, many Grantees (36 percent) reminded us that more funds would be needed to deliver services. Nearly 30 percent reported that the approach may be difficult to implement because of the different clinical and philosophical approaches to delivering care and differences in the type of clients served. Many family planning patients may not be comfortable receiving services together with various high risk populations. Indeed, 13 percent were concerned that the stigma often associated with STD services would be also be identified with family planning services and decrease access to care for some clients. About 14 percent worried that the emphasis on disease prevention may overshadow the focus on pregnancy prevention and family planning.

FIGURE 21:
ADMINISTRATORS' PERSPECTIVES ON THE DISADVANTAGES OF INTEGRATING FAMILY PLANNING WITH STD SERVICES

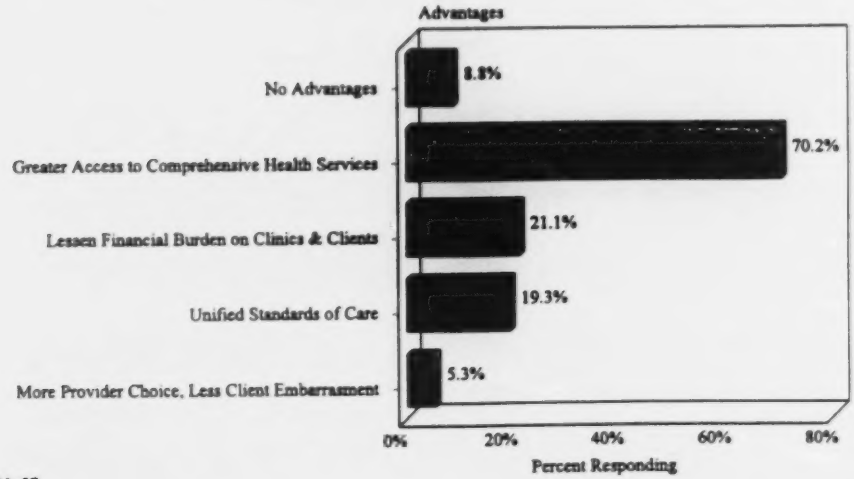


Should a Third-Party Reimbursement System be Used for Family Planning?

In addition to considering possibilities for modifying specific approaches to how family planning services are delivered, it is also appropriate that policy makers consider various approaches to funding or paying for family planning services. Particularly in light of the current debate on health care reform, considering the logistics of a national third party reimbursement system is especially relevant for family planning service providers.

Figure 22 presents Title X Administrators' reactions to a third-party reimbursement mechanism for family planning. The majority of Grantees (70 percent) saw this approach as a means for providing universal access to family planning, and comprehensive health and reproductive health care for low-income women. Twenty-one percent saw it as a way of lessening the financial burden currently carried by family planning providers and clients, and offering a more equitable way of allocating funds. Nineteen percent felt that a reimbursement system would lead to better quality control, unified standards of service delivery, and a common billing system. It would also increase women's ability to choose a provider and reduce the embarrassment some women associate with going to family planning clinics (5 percent).

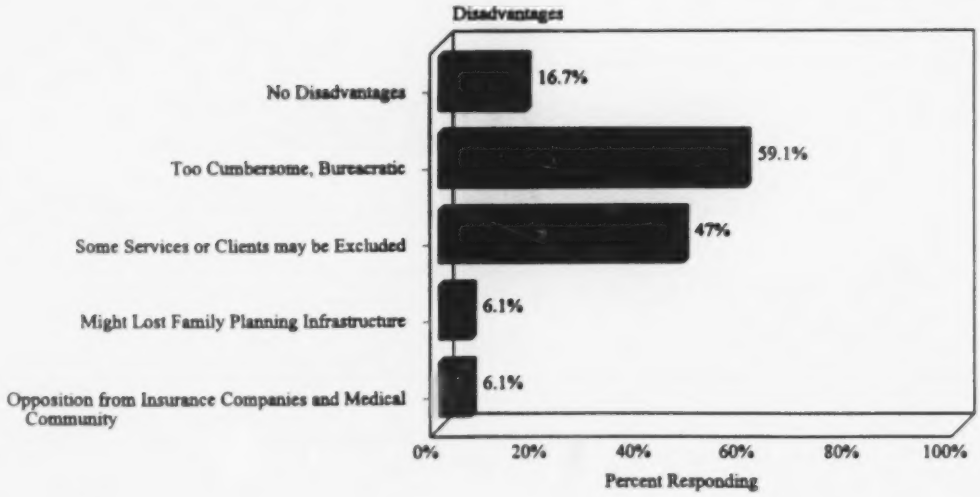
FIGURE 22:
ADMINISTRATORS' PERSPECTIVES ON THE ADVANTAGES OF USING THIRD PARTY REIMBURSEMENT FOR FAMILY PLANNING



N=57

On the other hand, as with any national effort, there is, Administrators felt, an increased likelihood of government involvement and bureaucratic red tape (see Figure 23). Grantees felt the reimbursement mechanism would fall prey to these problems as well. Sixty percent felt this approach would be associated with more government regulations, a focus on cost savings, and less emphasis on prevention. Nearly half of Grantees felt they could not be guaranteed that all family planning services would be covered, or that all family planning clients would be included in such a plan. Six percent expressed concern about losing the existing family planning infrastructure and confronting opposition from insurance companies and the medical community.

FIGURE 23:
ADMINISTRATORS' PERSPECTIVES ON THE DISADVANTAGES
OF USING THIRD PARTY REIMBURSEMENT FOR FAMILY PLANNING

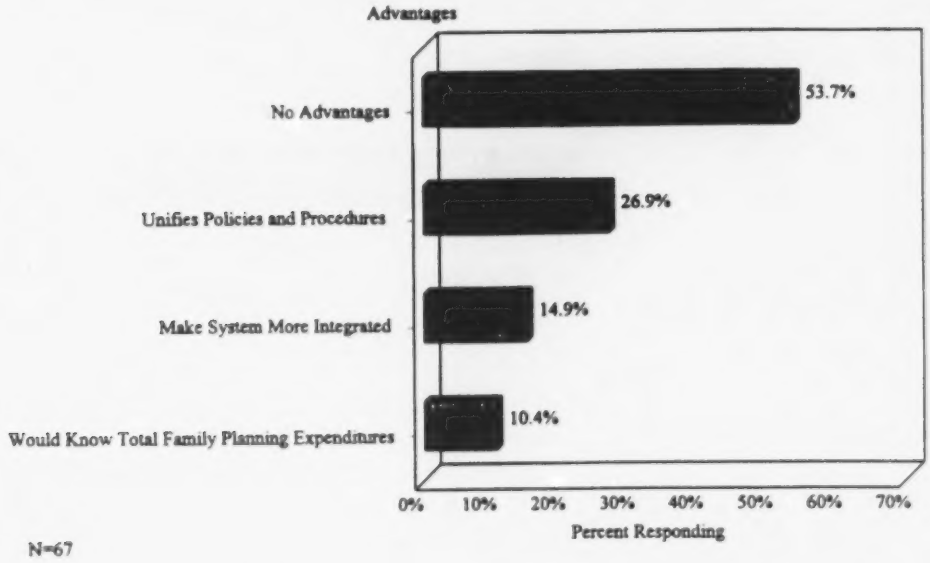


N=66

Should a Block Grant Approach be Used for Family Planning?

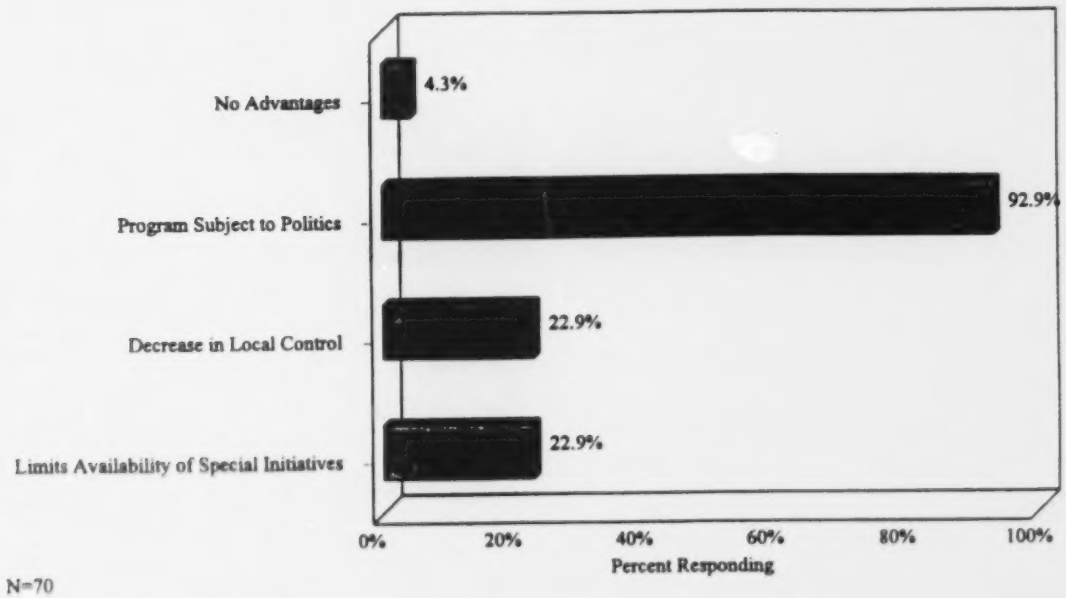
The final approach we asked Grantees to think about was using a block grant source of funding for family planning; Administrators' responses are presented in Figure 24. Not surprising, more than half of them saw no advantages to this approach at all. However, slightly more than one-quarter thought it would unify policies and procedures and maximize the revenues available for family planning. Grantees also felt this approach would allow providers to be more cognizant of family planning revenues (10 percent) and would help them integrate family planning with primary health care services (15 percent).

FIGURE 24:
ADMINISTRATORS' PERSPECTIVES ON THE ADVANTAGES OF A BLOCK GRANT OR STATE ADMINISTERED PROGRAM FOR FAMILY PLANNING



However, Grantees were very worried that a block grant approach would be subject to the political whims of the state (see Figure 25). Ninety-three percent of Grantees saw the potential to lose family planning services altogether given an unsympathetic state administration. States could also lose the ability to address special family planning services and special family planning target populations (23 percent). They also warned that this approach lends itself to increased bureaucratic red tape and regulations concerning service provisions there-by decreasing the control local authorities have over their programs.

FIGURE 25:
ADMINISTRATORS' PERSPECTIVES ON THE DISADVANTAGES OF A
BLOCK GRANT OR STATE ADMINISTERED PROGRAM FOR FAMILY PLANNING



N=70

In sum, Administrators saw both advantages and disadvantages associated with new approaches to family planning service delivery. Expanding family planning to include preventive approaches would meet a real need for STD screening, and other reproductive health and primary care, and would be convenient for women. Such an expansion could stretch available funds, and dilute the focus on family planning. Staff training would be needed and in some communities service duplication might occur.

Similarly, integrating family planning with MCH or with services to diagnose and treat STDs was viewed by Administrators as a way to provide more comprehensive care to women, but at the risk of weakening the focus on family planning and mixing populations (such as pregnant women, teens, and women needing STD screening) who have different needs and service preferences. Concerns were widespread that a block grant approach, while consolidating services, policies, and procedures, would expose family planning programs to political forces that could jeopardize the availability of family planning.

The need for greater and more reliable funding was expressed by most Administrators. Third party reimbursement mechanisms were viewed as a means to this important good. Greater regulation, uncovered services, a lessened emphasis on prevention, and a greater focus on cost savings were noted as possible negative consequences. However, Administrators noted that a general third party reimbursement strategy could lead to universal access to family planning, as well as comprehensive health and reproductive care.

IMPLICATIONS FOR FAMILY PLANNING POLICY AND HEALTH CARE REFORM

In this report we have tried to highlight findings from our interviews with State Family Planning Administrators, particularly Title X Grantees. The data reported here enhance our understanding of family planning service delivery at the state level and provide Administrators' perspectives about future family planning policy, information that, prior to this time, has not been presented.

Information from the State Survey suggests that during the past decade, Title X funding was generally insufficient to meet the demand for family planning services. Close to 90 percent of Title X administrators noted a decline in Title X funding between 1980 and 1989. Also during the 1980s, the demand for family planning services generally increased. Sixty-eight percent of Title X Grantees report an increased demand for sterilization services, 91 percent noted an increased need for STD screening and counseling, and 93 percent saw the demand for HIV counseling and testing increase. Administrators also reported their public monies provided more contraceptive services, particularly new methods, and follow-up services and referrals for abnormal Pap smears. With declining funds and increased need, it is not surprising that 98 percent of Administrators reported that funding fell short of service needs; in fact, 85 percent of Administrators felt that funding fell far short of the need for family planning services.

To compensate for diminished family planning funding and increased demand for family planning services, Title X Administrators made a conscious effort to become more efficient in delivering care and/or cut back on services. For example, Administrators modified the scope of services provided, laid off staff and froze staff salaries. Our data cannot provide information on whether the quality of family planning services has changed as a result of these measures, but we anticipate that a reduction in services at a time when demand was high would indicate that quality of services generally did not improve and may have been jeopardized in some instances.

In a context of fewer revenues and increased demand, state Administrators still provided a wide range of family planning services to their clients in 1991. All sources of revenues generally covered basic family

planning services, including contraceptives and pregnancy related services. Title X was the prime source of coverage for HIV related services, however. NORPLANT was only modestly covered under all sources of public family planning monies.

In addition, Administrators identified lack of funding and political controversies as their greatest source of difficulty in delivering family planning. They see the re-authorization of Title X and an increase in family planning outreach to special clients as important ways to improve the delivery of Title X services to low-income women. They also recommend a revision in Title X regulations, and increased coordination of Title X with MCH, Title XX, State and Medicaid administrators.

Focusing on overall family planning service delivery, Title X Grantees note that a more comprehensive approach to family planning will be important for the 1990s. Most acknowledge that there are advantages to expanding family planning services to include preventive care, MCH or STD services, or to adopting a macro-level funding strategy for family planning. The potential benefits of such broad approaches include increased access to family planning and health care for low-income women and various special populations (i.e., post-partum clients, and persons at risk for STDs/HIV). Administrators see these comprehensive approaches as a way to reduce the financial burden for family planning currently carried by public family planning providers.

On the other hand, Title X Administrators worry that such approaches will not garner consistent government and community support; these strategies will not be coupled with increased revenues, staff training/retraining, and the focus on family planning could be diluted or lost entirely. Consequences such as these could inadvertently undermine family planning.

These findings have many implications for family planning service delivery during the next decade, particularly in the context of national health care reform. The focus of the health care reform effort has been on how to contain health care costs and provide universal coverage. It is not clear these efforts will necessarily increase access to family planning services. Most third party payers do not cover preventive care such a family planning visit or contraceptives. Furthermore, if Medicaid or Title X is modified to offset the cost of funding

national health care reform, and the new system does not cover family planning or the scope of family planning services is diminished, then family planning clients will have less access to family planning services.

In addition, the structure of a health service delivery system under national health care reform is still unknown. If health services are to be provided through a system of community based health centers or clinics, depending on whether the family planning provider network will be included in that system, and/or how the current infrastructure will be modified, again, reform could inadvertently reduce access to family planning and jeopardize family planning service delivery. Full coordination and cooperation of all family planning providers will be instrumental in supporting the health care delivery needs of the nation no matter what type of health reform plan is put into place.

As the details concerning coverage and the logistics of implementation about health care reform unfold, there are many issues surrounding family planning service delivery at the state level that need to be addressed and considered in the debate on health care reform. Our report suggests that the following concerns should be addressed:

- ***Funding for family planning should be adequate enough to meet states' service delivery needs; free or low cost contraceptive supplies should be guaranteed. If categorical funding for family planning is eliminated, comparable funding mechanisms must be in place to assure continued funding for family planning.***

One of the greatest challenges for family planning in the coming decade will be to consistently secure adequate revenue levels (public or private) for family planning service delivery. Indeed, state and regional family planning administrators have directed services to more clients who have presented a greater need for services over the past 12 years. They have done this in a variety of ways, although the impact on the quality of care is unknown. To continue to ask states to disproportionately carry the burden for delivering services to low-income women will only continue to tax a system that is reaching or may be past the limits of what it can bear. While it is presumed that health care reform will reduce financial barriers to health care, particularly for low-income persons and the working poor, health care reform packages do not clearly delineate what

preventive care services are covered, and what family planning or reproductive care services are included under preventive care. Health care reform proposals should precisely state which preventive services are covered and those services should include the full range of family planning services currently provided by family planning providers. This includes the provision of prescriptions for contraceptives and other contraceptive supplies. The inclusion of contraceptives under the prescriptions subcomponent of health care reform is particularly risky. If modifications are made to the type of prescriptions that are covered, or the level of co-pays required, this could have important implications for low-income clients seeking to practice family planning or to maintain their reproductive health.

In addition, categorical programs, such as Title X, may be phased out to help pay for a national health care reform. While a lack of coordination between various categorical programs can lead to duplication of services and efficient use of resources, many states depend on categorical programs for family planning and reproductive health care for low-income populations. As noted earlier in this report, some states are entirely dependent upon Title X monies to deliver family planning services to low-income women. This was particularly true for those states where a non-state entity such as Planned Parenthood or a regional family planning council was the Title X Grantee for the entire state. Thus, the elimination of categorical funding for family planning without a comparable funding mechanism could virtually eliminate access to affordable reproductive health care for a large proportion of low-income clients. While it is presumed that low-income clients could then secure family planning services from a range of other providers, it is not clear that hospitals, HMOs or private physicians currently have the capacity to handle the increased client load or the skills to handle a diverse range of family planning clients. For example, managers participating in the clinic survey (Burt, Aron, and Schack, 1994) believe the quality of health care available to their clients would decline if specialized clinics were forced to close due to health care reform. Many noted that there were not enough doctors in their community to serve clients, particularly low-income clients, and that reproductive health problems among low-income people or teenagers may be ignored or mismanaged.

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In addition, clinic managers felt that other providers would not be given the personalized care that family planning clinics provide, particularly the one-to-one counseling and education. Indeed, in the consumer survey (Sonenstein, Schulte, and Levine 1994), all women said that having things explained to them was an important factor in choosing their provider, and providers in clinics were found to spend more time consulting with patients than either private providers or those working in HMOs.

Administrators identified many advantages for having family planning included under a health care reform package, but their concerns about the decline in access to care and the quality of care are important considerations for health care reform.

- ***The family planning service delivery network should be preserved; coordination between family planning administrators and local providers of the Title X, MCH, Title XX, State and Medicaid agencies should be increased.***

Health care reform proposals tend to focus on the financial mechanisms of health care and less on the health care service delivery network. Furthermore, there is virtually no discussion, at least among policy makers, about the kind of impact that a new health care financing mechanism might have on the current system of health care delivery. The impact is potentially devastating for the family planning service delivery infrastructure. Admittedly, publicly funded family planning services are provided through a patchwork of services delivered by different sectors of the public and private health community. This leads to duplication of services on the one hand, and fragmentation of services on the other. Although the focus of the state survey was not on coordination of providers across various public sectors, many administrators reported that increased coordination would improve family planning services to low income women. Securing coordination between regional family planning providers and state agencies will be particularly important but especially challenging. However, many state and regional family planning agencies do coordinate their services and family planning programs with MCH services. According to a recent report by the Association for Maternal and Child Health Programs (1993), most state MCH programs have a commitment to and interest in family planning service delivery, and administrators from both programs frequently report collaboration between programs.

Increased coordination will not only enhance service delivery for low-income women, but it will strengthen the family planning network, something which could prove crucial for health care reform. As some health care reform packages propose a limited number of state-level health care provider networks, it is crucial that family planning providers find a way to be included in this provider network. However, state-level family planning agencies, such as State Health Departments, and particularly regional family planning councils, may not be poised to tap into such a provider network unless coordination of all family planning providers is increase.

- ***A comprehensive approach to family planning service delivery is warranted; such an approach requires sufficient funding and full government and local support.***

Family planning administrators have been providing a wide range of contraceptive services to a wide range of clients for many years. Furthermore, clients seeking care through family planning providers are presenting an increased demand for STD services, HIV risk assessment, and follow-up services for reproductive and other primary health problems. Being able to expand the scope of family planning services appears to be a logical way to enhance family planning service delivery to low-income clients. However, the broader approach to family planning service delivery naturally implies increased funding and government support of reproductive health care for low-income populations. Family planning embedded within a larger primary health care system would be ideal, so long as it can be adequately paid for and can receive adequate focus within the larger health care system.

Health care reform, if it addresses the needs described above, can achieve universal access to health care for all persons in need. However, family planning and reproductive health care are but a fraction of the entire health care puzzle. Thus, it is easy to overlook these important criteria as the final health reform package takes shape. However, many low-income clients may not be adequately served by the new system of care if these criteria are not met. Current health care reform proposals must address these criteria in order to ensure universal health care coverage, including reproductive health care, for all populations.

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